Michael Doherty, MD • Todd Durham, MD • Brian Fedeson, MD • Michael Knox, MD • Jarrod MacFarlane, DO • Jay Morrow, MD
Bryan Mustert, MD • Chirag Patel, MD • William Rozell, DO • William Slater, MD • Jeff VanErp, MD • Manish Varma, MD

Welcome! Thank you for choosing Advanced Radiology Services: Interventional Radiology.

Please take a moment to review the following information regarding your appointment.

Date: _____

Time: _____

Physician: _____

Location: 3264 North Evergreen Drive
Lower Level, Suite 100
Grand Rapids, MI 49525
(a map has been included for your convenience)

Please bring the following:

- A current list of medications
- All active insurance cards
- Any CDs or discs (if you were instructed to bring them to your appointment)
- Your driver's license and the attached forms (complete prior to appointment)

If you have any questions, or if you need to reschedule your appointment, please call (616) 459-7225, and select option 3.

We look forward to meeting you.

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FROM THE WEST (I-196 Eastbound):

1. Take I-196 heading Eastbound
2. Merge onto I-96, once on I-96 keep right until you see Exit 38
3. Take Exit 38 to East Beltline Ave
4. Turn left onto East Beltline Ave, keep in right lane
5. Cross 3 Mile Road
6. Go 0.4 miles to North Evergreen Drive (3rd street on the right hand side once you pass the light)
7. Turn right onto North Evergreen Drive
8. Advanced Radiology Services will be the 1st building on the right hand side of the road (small two story building)
9. Take the elevator down to the Lower Level

FROM THE NORTH (131 Southbound):

1. Take 131 South
2. Merge onto I-196 heading Eastbound
3. Merge onto I-96, once on I-96 keep right until you see Exit 38
4. Take Exit 38 to East Beltline Ave
5. Turn left onto East Beltline Ave, keep in right lane
6. Cross 3 Mile Road
7. Go 0.4 miles to North Evergreen Drive (3rd street on the right hand side once you pass the light)
8. Turn right onto North Evergreen Drive
9. Advanced Radiology Services will be the 1st building on the right hand side of the road (small two story building)
10. Take the elevator down to the Lower Level

OR (M37 South)

1. Take M37 (Alpine Avenue) South
2. Take I-196 Eastbound
   (continue on from #3 listed above)

FROM THE EAST (I-96 Westbound):

1. Take I-96 Westbound
2. Take Exit 38, East Beltline Ave
3. Turn right onto East Beltline Ave
4. Cross 3 Mile Road
5. Go 0.4 miles to North Evergreen Drive (3rd street on the right hand side once you pass the light)
6. Turn right onto North Evergreen Drive
7. Advanced Radiology Services will be the 1st building on the right hand side of the road (small two story building)
8. Take the elevator down to the Lower Level

FROM THE SOUTH (131 Northbound):

1. Take 131 North
2. Merge onto I-196 heading Eastbound
3. Then merge onto I-96, once on I-96 keep right until you see Exit 38
4. Take Exit 38 to East Beltline Ave
5. Turn left onto East Beltline Ave, keep in right lane
6. Cross 3 Mile Road
7. Go 0.4 miles to North Evergreen Drive (3rd street on the right hand side once you pass the light)
8. Turn right onto North Evergreen Drive
9. Advanced Radiology Services will be the 1st building on the right hand side of the road (small two story building)
10. Take the elevator down to the Lower Level

OR (M44 North)

1. Take M44 North
2. Cross 3 Mile Road
   (continue on from # 7 listed above)

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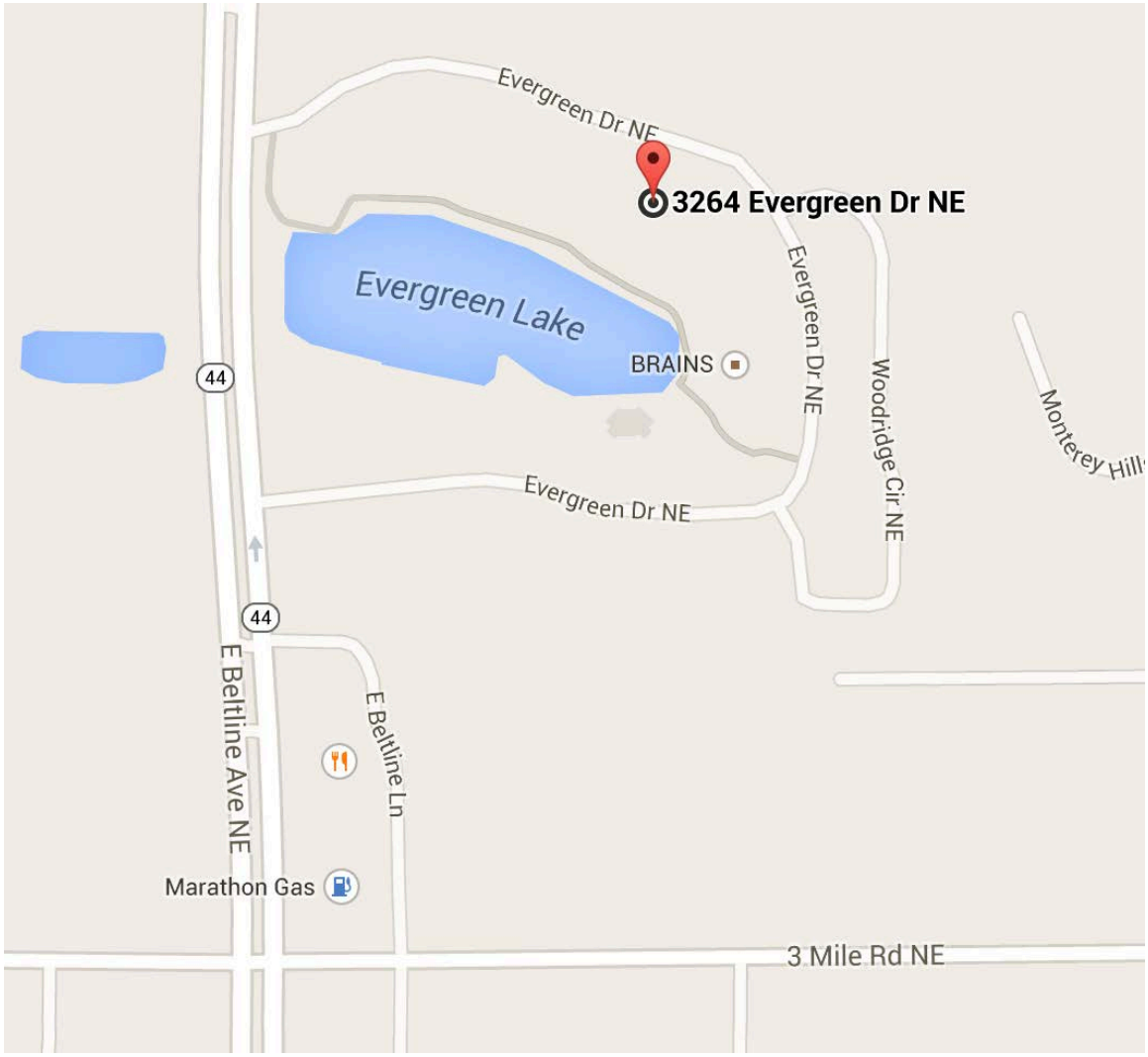
Map to: [Advanced Radiology Services]
3264 North Evergreen Drive NE
Grand Rapids, MI 49525



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New Patient Information

Patient Name: _____

Reason for visit: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

What prior evaluation have you had for this problem: _____

_____

List any medications (including dosage) that you take on a regular basis:

Medication	Dosage

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medications:

_____

Have you had a reaction to sedation or anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

If you are female are you pregnant? ☐ Yes ☐ No
If yes, how many weeks? _____

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Are you currently or have you in the recent past been treated for any of the following medical conditions? (Check all that apply)

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fib
☐ Bleeding disorder
☐ Blood Clots
☐ Cancer
☐ Chest Pain/Angina
☐ Chronic Pain
☐ Congenital Disease
☐ CHF
☐ COPD
☐ Dementia
☐ Depression/Anxiety
☐ Diabetes
☐ Diverticular Disease
☐ Elevated Cholesterol/lipids
☐ GERD
☐ Gastrointestinal Bleeding
☐ Glaucoma
☐ Hepatitis
☐ Hypertension
☐ Headache
☐ Inflammatory Bowel Disease
☐ Kidney Stone/Failure
☐ Migraines
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Pneumonia
☐ Pancreatitis
☐ Pulmonary Embolism
☐ Renal Insufficiency
☐ Swelling of Legs
☐ Seizures
☐ Stroke/TIA
☐ Thyroid Disorder

If you have Diabetes:
What type: _____
What treatment are you following: _____

Please list any other medical problems: _____

_____

_____

Have you had any of the following surgeries? (Check all that apply)

☐ Aneurysm Repair/Coiling
☐ Angioplasty/Stent
☐ Appendectomy
☐ Bariatric
☐ Bowel
☐ Bladder
☐ CABG/Heart Valve
☐ Cataract
☐ Gallbladder Removal
☐ Hernia
☐ Hysterectomy
☐ Kidney
☐ Laminectomy
☐ Mastectomy/Lumpectomy
☐ Orthopedic/Joint
☐ Pacemaker
☐ Thyroidectomy
☐ Transplant
☐ Tubal Ligation/Vasectomy
☐ TURP
☐ VP Shunt
☐ Vascular

Please list any surgeries not listed above: _____

_____

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Family History:
Please list any health problems your family members have experienced including cause of death (if deceased):

Father: _____

Mother: _____

Siblings: _____

Social History:
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

Do you use tobacco: ☐ Yes ☐ No
If yes, what types: ☐ Smoke cigarettes ☐ Chewing tobacco ☐ Other (e.g. environmental exposure)
If yes, how often: _____ Have you quit: ☐ Yes ☐ No Date: _____

Do you drink alcohol: ☐ Yes ☐ No
If yes, how often: _____ Have you quit: ☐ Yes ☐ No

Have you experienced any of the following? (Check all that apply)

☐ Abdominal Pain
☐ Back Pain/Injury
☐ Bleeding/Bruising
☐ Blood/Change in your bowel movements
☐ Blood in your urine
☐ Change in your vision
☐ Change in mood/Anxiety/Depression
☐ Chest Pain/Palpitations
☐ Chills
☐ Chronic Cough
☐ Dizziness
☐ Fatigue
☐ Fever/Sweats
☐ Frequency with urination
☐ Headache
☐ Hives, Itching
☐ Joint Pain
☐ Menstrual problems
☐ Nausea
☐ Pain/Cramping in legs when walking
☐ Problems with swallowing
☐ Ringing or buzzing in your ears
☐ Shortness of Breath
☐ Swelling in your legs
☐ Visual changes
☐ Vomiting
☐ Weakness
☐ Weight Loss

This form is accurate and current to the best of my knowledge.

_____ _____
Patient Signature Date

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Flu Vaccine Questionnaire

Patient Name: _____
Date of Birth: _____
Today's Date: _____

Have you had an influenza vaccine: ☐ Yes ☐ No

If yes, date of influenza vaccine: _____

If no, reason why: _____

Have you had a pneumonia vaccine: ☐ Yes ☐ No

If yes, date of pneumonia vaccine: _____

If no, reason why: _____