MXC IMAGING SPECIALISTS

Chippewa Valley VEIN CENTER AND ENDOVASCULAR SPECIALISTS

Interventional Radiology History and Physical

Date: _____

Your Name: _____ Date of Birth: _____ Age: ____ Sex: ❑ M ❑ F

Primary Physician: _____ Referred By: _____ ❑ Self

Who should receive a letter regarding today's visit: ❑ Primary Physician ❑ Referring Physician ❑ Other _____

Chief Complaint: *Please describe why you are here to see the doctor today.*

_____

_____

History of Present Illness: *Your doctor will complete this section – please continue below with Medications.*

(Brief 1-3, Ext ≥4: *location, quality, severity, duration, timing, context, modifying factors, associated signs & symptoms)*

_____

_____

_____

_____

_____

Medications: *Include oral contraceptives, tetracycline, aspirin, Plavix, Coumadin*

_____

_____

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Allergies: *Include iodine, contrast dye, latex*

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Past Medical History: *Please indicate if you have or have had any of the following.*

❑ *High blood pressure* ❑ *High cholesterol* ❑ *Diabetes* ❑ *Kidney failure*
❑ *Heart disease* ❑ *Cancer* ❑ *Lung disease* ❑ *Stroke*
Details/other(please list):

Past Surgical History: *Please indicate if you have had any of the following*

❑ *Gallbladder removal* ❑ *Heart bypass* ❑ *Hernia repair* ❑ *Carotid artery surgery*
❑ *Bowel surgery* ❑ *Leg / arm bypass*
Details/other(please list):

Family History: *Please list any health conditions in your family, especially your mother, father, sisters, brothers.*

_____

_____

_____

Social History:

❑ *Smoke* *Packs per day?* ____ *Years?* ____ *Quit? When?* _____
❑ *Drink alcohol* ❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Live alone*
Occupation:

Review of systems: *Please indicate if you have any of the problems listed below.*

General:
- ❑ *Fever or chills*
- ❑ *Night sweats*
- ❑ *Loss of appetite*
- ❑ *Fatigue*
- ❑ *Weight loss or gain*

Eyes:
- ❑ *Glasses or contact lenses*
- ❑ *Blurred or double vision*
- ❑ *Visual loss*
- ❑ *Pain*
- ❑ *Redness*

Ear, Nose, Mouth, Throat:
- ❑ *Hearing loss*
- ❑ *Ear pain*
- ❑ *Ringing in ears*
- ❑ *Sinus congestion*
- ❑ *Frequent nose bleeds*
- ❑ *Hoarseness*
- ❑ *Difficulty swallowing*

Cardiovascular:
- ❑ *Chest pain*
- ❑ *Palpitations*
- ❑ *Heart murmur*
- ❑ *Heart attack*
- ❑ *Pacemaker*
- ❑ *Congestive heart failure*
- ❑ *Stroke*
- ❑ *Leg swelling*

Respiratory:
- ❑ *Chronic cough*
- ❑ *Shortness of breath*
- ❑ *Wheezing*
- ❑ *Emphysema*
- ❑ *Asthma*
- ❑ *Tuberculosis or TB*

Gastrointestinal:
- ❑ *Heartburn/reflux*
- ❑ *Nausea/vomiting*
- ❑ *Abdominal pain*
- ❑ *Diarrhea*
- ❑ *Constipation*
- ❑ *Change in BMs*
- ❑ *Bloody/black stool*
- ❑ *Vomiting blood*
- ❑ *Jaundice*
- ❑ *Liver disease*
- ❑ *Hepatitis*
- ❑ *Stomach or duodenal ulcers*

Genitourinary:
- ❑ *Frequent urination*
- ❑ *Painful urination*
- ❑ *Blood in urine*
- ❑ *Kidney stones*
- ❑ *Prostate problems*
- ❑ *Kidney disease or failure*

Musculoskeletal:
- ❑ *Joint pain or stiffness*
- ❑ *Joint swelling*
- ❑ *Joint replacement*
- ❑ *Back pain*
- ❑ *Leg pain with walking*
- ❑ *Muscle weakness*

Skin and Breast:
- ❑ *Easy bruising*
- ❑ *Rash*
- ❑ *Sores/ulcers*
- ❑ *Hair loss*
- ❑ *Itching*
- ❑ *Breast lumps*
- ❑ *Nipple Discharge*
- ❑ *Abnormal Mammogram*

Neurological:
- ❑ *Frequent headaches*
- ❑ *Numbness/tingling*
- ❑ *Seizures*
- ❑ *Head injury*
- ❑ *Stroke*
- ❑ *Memory loss*
- ❑ *Dizziness*

Psychiatric:
- ❑ *Anxiety*
- ❑ *Depression*
- ❑ *Insomnia*
- ❑ *Drug abuse*
- ❑ *Alcohol abuse*

Endocrine:
- ❑ *Diabetes*
- ❑ *Thyroid problems/goiter*
- ❑ *Heat or cold intolerance*

Hematologic/Lymphatic:
- ❑ *Easy bruising*
- ❑ *Easy bleeding*
- ❑ *Anemia*
- ❑ *Enlarged glands*
- ❑ *AIDS or HIV positive*

Allergic / Immunologic:
- ❑ *Allergy to penicillin/other antibiotic*
- ❑ *Allergy to iodine or IVP dye*
- ❑ *Allergy to local anesthetic*
- ❑ *Food allergies*
- ❑ *Reaction to general anesthesia*

Gynecological:
- ❑ *Irregular or heavy periods*
- ❑ *Bleeding between periods*
- ❑ *Menopause*

Patient Signature: _____ **Date: _____**

Physical Exam: *For office use* *(PF 1, EPF 2-4, Det 5-7, Comp 8+)*

Vital Signs (3)	Temp:	BP:	HR:	RR:	Weight:
General	❑Well developed	❑Well nourished	❑No acute distress	❑No acute pain	
Eyes	❑PERRL	❑EOM nl	❑Conjunctiva nl	❑Lids nl	
ENMT	❑EAC nl	❑TM nl	❑Nasal Mucosa nl	❑Oropharynx nl	❑No JVD
CV	❑RRR	❑No murmurs	❑Abd Ao nl	❑No abd bruits	❑No carotid bruit
Resp	❑Good resp effort	❑No rales,rhonchi	❑No wheezes	❑Symmetry	
GI	❑No masses	❑No tenderness	❑Bowel Sounds nl	❑No distention	
GU	❑No masses	❑No tenderness			
Msk	❑ROM nl	❑Strength nl	❑No deformity		
Skin	❑No edema	❑No varicosities	❑No ulcers	❑No hair loss	
Neuro	❑Normal speech	❑CN II-XII intact	❑Motor fn nl	❑Sensory fn nl	
Psych	❑Oriented to p/p/t	❑Mood nl			
Heme/Lymph/Imm	❑No adenopathy				

PULSES:	**RAD**	**CF**	**POP**	**DP**	**PT**
RIGHT:					
LEFT:					

Comments:

Data (Lab/Imaging Results):

ASSESSMENT:

PLAN:

Time spent with patient: ❑10 ❑20 ❑30 ❑45 ❑60 minutes

Nurses Initials: _____ **Physician Signature:** _____ **Date:** _____