How did you hear about IVY Cardiovascular & Vein Center?
□ Physician Referral
□ Online/Advertisement
□ Family/Friend Referral
□ Other: ______________________________

PATIENT INFORMATION

Date: ______________________ Primary Language Spoken: _________________________

Name: ______________________________ DOB: ____________________ Age: ________

Gender: □Male □Female Race/Ethnicity: □Asian □Black/African American □Hispanic/Latino □ White

Address: _________________________________City: _______________Zip Code:_______

Phone Number: _____________________ Email Address: __________________________

Primary Care Physician: _______________________ Phone Number: ___________________

Referring Physician (if different): ___________________ Phone Number: __________________

Reason for Visit: ____

Pharmacy: ___________________________ Address: ______________________________

Phone Number: ________________ Medication Supply Preference: □30-day supply □90-day supply

EMERGENCY CONTACT

Emergency Contact: _________________________ Phone Number: ____________________

Relationship: □Spouse □Child □Parent □Other: ______________________________________

INSURANCE

Primary Insurance: ______________________ Policy#: _____________ Group#: ___________

Subscriber: _________________________________ Subscriber DOB: __________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ______________________________

Secondary Insurance: ____________________ Policy#: _____________ Group#: ___________

Subscriber: _________________________________ Subscriber DOB: __________________

Relationship to Subscriber: □Self □Spouse □Child □Other: ______________________________

Name: ______________________________ DOB: ______________________

Please check all that apply.

MEDICAL HISTORY

- ☐ Anemia
- ☐ Aortic Aneurysm
- ☐ Arrhythmia/Irregular Heartbeat
  - ☐ Atrial fibrillation (A. fib)
  - ☐ Atrial flutter
  - ☐ Bradycardia
  - ☐ Supraventricular tachycardia (SVT)
  - ☐ Palpitations
  - ☐ Ventricular Arrhythmia
- ☐ Asthma/COPD/Emphysema
- ☐ Blood Clots
  - ☐ Deep Vein Thrombosis (DVT)
  - ☐ Pulmonary Embolism (PE)
- ☐ Bleeding Disorder
- ☐ CVA/Stroke/TIA
- ☐ Cancer
- ☐ Cardiomyopathy/Heart Failure
- ☐ Carotid Artery Disease
- ☐ Congenital Heart Disease
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Endocarditis
- ☐ GERD
- ☐ GI Bleed
- ☐ Gastrointestinal Ulcer
- ☐ Heart Valve Abnormalities/Heart Murmur
- ☐ Hyperlipidemia/ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Neuropathy
- ☐ Peripheral Vascular Disease
  - ☐ Peripheral Artery Disease
  - ☐ Venous Disease
  - ☐ Varicose Veins
- ☐ Pulmonary Hypertension
- ☐ Renal Artery Stenosis
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Syncope
- ☐ Thyroid Disease
- ☐ Other: ______________________

SURGICAL HISTORY

Procedure	Date	Physician
☐ Cardiac Catheterization	Date: ________	Physician: ______________
☐ Cardioversion	Date: ________	Physician: ______________
☐ Coronary Angioplasty/Stent	Date: ________	Physician: ______________
☐ Coronary Artery Bypass (CABG)	Date: ________	Physician: ______________
☐ ICD Placement	Date: ________	Physician: ______________
☐ Pacemaker Placement	Date: ________	Physician: ______________
☐ Peripheral Vascular Angioplasty/Stent	Date: ________	Physician: ______________
☐ Peripheral Artery Bypass/Endarterectomy	Date: ________	Physician: ______________
☐ Radiofrequency Ablation	Date: ________	Physician: ______________
☐ Heart Valve Repair/Replacement	Date: ________	Physician: ______________
☐ Aneurysm Repair	Date: ________	Physician: ______________
☐ Carotid Surgery	Date: ________	Physician: ______________
☐ Amputation	Date: ________	Physician: ______________
☐ Other: ________________	Date: ________	Physician: ______________

Name: ____ DOB: ____________________________

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Occupation: _____________________________

Do you consume alcohol? ☐Yes ☐No ☐Former
Frequency: ________________

Do you smoke/use tobacco? ☐Yes ☐No ☐Former
Number of years: ______________
Packs per day: ________________

Do you use illicit drugs? ☐Yes ☐No ☐Former
Substance type: ___________________

Do you exercise regularly? ☐Yes ☐No
If YES, describe: _______________________________

FAMILY HISTORY

Is there any family history of:

☐ Myocardial Infarction/Heart Attack	☐Yes	☐No	Family Member(s): _______________________
☐ Stroke/CVA	☐Yes	☐No	Family Member(s): _______________________
☐ Coronary Artery Disease	☐Yes	☐No	Family Member(s): _______________________
☐ Diabetes	☐Yes	☐No	Family Member(s): _______________________
☐ Hypertension (High Blood Pressure)	☐Yes	☐No	Family Member(s): _______________________
☐ Sudden Death	☐Yes	☐No	Family Member(s): _______________________
☐ Hyperlipidemia/High Cholesterol	☐Yes	☐No	Family Member(s): _______________________

REVIEW OF SYSTEMS

Recent weight gain or loss	☐Yes	☐No	Swelling of ankles/feet	☐Yes	☐No
Chest pain, pressure or tightness	☐Yes	☐No	Non-healing sores on legs/feet	☐Yes	☐No
Shortness of breath at rest	☐Yes	☐No	Leg pain/cramps with walking	☐Yes	☐No
Shortness of breath with activity	☐Yes	☐No	Leg pain at rest	☐Yes	☐No
Short of breath lying flat	☐Yes	☐No	Fatigue/malaise	☐Yes	☐No
Cough	☐Yes	☐No	Weakness	☐Yes	☐No
Heart palpitations/heart racing	☐Yes	☐No	Headaches	☐Yes	☐No
Dizziness/vertigo/fainting	☐Yes	☐No	Changes in vision	☐Yes	☐No
Fever/Chills	☐Yes	☐No	Memory loss	☐Yes	☐No

Name: ______________________________ DOB: ______________________

ALLERGIES

Do you have any allergies to medications, foods, latex, seafood/IV dyes? ◻Yes ◻No

If YES, please list:

______________________ Reaction: ______________________

______________________ Reaction: ______________________

______________________ Reaction: ______________________

______________________ Reaction: ______________________

MEDICATIONS

Medication Name	Dose	Frequency