Vascular Specialists of Mobile, P.C.

NAME: _____ DATE: _____ CHART: _____

AGE: _____ SEX: _____ OCCUPATION: _____

The following information is required by CMS (Center for Medicare and Medicaid Services) for additional statistical information gathering. The data will strictly be used for electronic health record meaningful use.

Please put an X next to each of the following that describes you:

RACE: White: _____ Black, African American: _____ Hispanic or Latino: _____ other: _____
LANGUAGE: English _____ Other _____

REFFERING MD NAME: _____ PHONE NUMBER: _____

PREFFERED PHARMACY: _____ CITY: _____ STATE: _____

REASON FOR VISIT: _____

SURGERIES &DATES: _____

_____

MEDICAL HISTORY/HOSPITALIZATIONS, DATES AND REASONS: _____

_____

MEDICATIONS & DOSAGE: _____

_____

FAMILY MEDICAL HISTORY: _____

_____

DO YOU SMOKE? NO _____ YES _____ # PACKS PER DAY _____ #YEARS SMOKED _____

HAVE YOU EVER SMOKED? NO: _____ YES: _____

ALCOHOL CONSUMPTION: _____

LIST ANY MEDICATION ALLERGIES: _____

_____

ANY OTHER ALLERGIES: _____

SEE REVERSE

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING?

	YES	NO	EXPLAIN
ALLERGIES			
PRIOR STROKES			
DIZZINESS/ BLACKOUTS			
BLIND SPELLS			
EAR/NOSE/ THROAT PROBLEMS			
THYROID DISORDER			
LUNG CONDITION			
HIGH BLOOD PRESSURE			
DIABETES			
HEART PROBLEMS			
STOMACH/LIVER PROBLEMS			
GALLBALDDER/COLON PROBLEMS			
SKIN CONDITIONS			
BONE/JOINT PROBLEMS			
BLEEDING DISORDERS			
LEGS/DIFFICULTY WALKING/SWELLING			
PROSTATE PROBLEMS (MEN)			
OTHER PROBLEMS			

**********DO NOT WRITE IN THE AREA BELOW**********

HISTORY/PHYSICAL BP _____RT _____LT WEIGHT_____HEIGHT_____

NURSE'S NOTES

PHYSICAL EXAM

PULSE STATUS

	CAROTID	RADIAL	ABD	FEM	POP	DP	PT
LEFT							
RIGHT							

NAME_____ CPT#_____

CHART_____ TODAY _____

DATE_____ RETURN _____