VASCULAR ASSOCIATES OF SAN DIEGO

Vascular & Endovascular Specialists
Board Certified in Vascular Surgery

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Vincent J. Guzzetta, M.D., F.A.C.S.
Patrick R. Cook, D.O., F.A.C.S., R.P.V.I.
Scott E. Musicant, M.D., F.A.C.S.
Thomas T. Terramani, M.D., F.A.C.S.

Patient Information Form

Date:		Name:			
Height:		Weight:		Age:		Occupation:	
						Preferred Pharmacy:	

MEDICAL HISTORY

Yes	No	Have you ever had:	If yes, date:
		Weight loss or gain	
		Fevers or chills	
		Back pain or injury	
		Arthritis	
		Bleeding tendency	
		Hepatitis or HIV	
		Diabetes	
		Thyroid disorder	
		High cholesterol	
		Pneumonia	
		Asthma or emphysema	
		Heart attack	
		Chest pain (angina)	
		Irregular heart beat	
		High blood pressure	
		Stroke	
		Epilepsy or convulsions	
		Asthma or emphysema	
		Alcohol addiction	
		Drug addiction	
		Leg pain when walking	
		Phlebitis (vein clot in legs	
		Constipation	
		Diarrhea	
		Bloody or dark stools	
		Urine bleeding or stones	
		Other serious medical illness	
Please specify:			

Allergies: (Medications, tape, latex, iodine, dye, etc/)

Social History:

Do you use alcohol? Yes: ☐ No: ☐

If yes, how much/often?

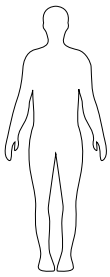
Do you or have you ever smoked? Yes: ☐ No: ☐

Packs per day: How many years?

If you have quit, when?

Family History:

Has anyone in your family had:		Who?
Stroke:	Yes: ☐ No: ☐	
Heart Attack:	Yes: ☐ No: ☐	
Diabetes:	Yes: ☐ No: ☐	
Aortic Aneurysm:	Yes: ☐ No: ☐	
Varicose Veins:	Yes: ☐ No: ☐	



Past Operations and approximate dates:

VASCULAR ASSOCIATES OF SAN DIEGO

Vascular & Endovascular Specialists
Board Certified in Vascular Surgery

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Vincent J. Guzzetta, M.D., F.A.C.S.
Patrick R. Cook, D.O., F.A.C.S., R.P.V.I.
Scott E. Musicant, M.D., F.A.C.S.
Thomas T. Terramani, M.D., F.A.C.S.

Patient Information Form - continued

Date:		Name:	

MEDICATIONS Please list all medications that you are currently taking, including over-the-counter medications.

Name	Dosage	How often

VASCULAR ASSOCIATES OF SAN DIEGO

Vascular & Endovascular Specialists
Board Certified in Vascular Surgery

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Vincent J. Guzzetta, M.D., F.A.C.S.
Patrick R. Cook, D.O., F.A.C.S., R.P.V.I.
Scott E. Musicant, M.D., F.A.C.S.
Thomas T. Terramani, M.D., F.A.C.S.

Personal Information Release

My personal health information, either verbally or written, my be released to the following:

NAME:	PHONE #
RELATIONSHIP:	LICENSE #:

NAME:	PHONE #
RELATIONSHIP:	LICENSE #:

NAME:	PHONE #
RELATIONSHIP:	LICENSE #:

PATIENT SIGNATURE:	DATE:

VASCULAR ASSOCIATES OF SAN DIEGO

Vascular & Endovascular Specialists
Board Certified in Vascular Surgery

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Vincent J. Guzzetta, M.D., F.A.C.S.
Patrick R. Cook, D.O., F.A.C.S., R.P.V.I.
Scott E. Musicant, M.D., F.A.C.S.
Thomas T. Terramani, M.D., F.A.C.S.

Patient Information Form

Patient's Name:			Home Phone:			Cell phone:	
Address:							
Email:							
Birthdate:		Age:		Social Security No.			
Marital Status:		Sex:	M: ☐ F: ☐	Ethnicity:		Declined: ☐	
Patient's Employer:			Occupation:			Work phone:	
Spouse or Guardian:			Spouse Employer:			Work phone:	

Patient's Insurance:		ID#:	
Address:			
Phone:			
Subscriber's Name:		Email:	
Secondary Insurance:		ID#:	

Family Physician:			Referred by:		
Emergency Contact:				Phone:	
Address:			Relationship:		

I hereby authorize and request _____ Insurance Company to assign directly to your physician all payments due for services rendered by said doctor.

I understand that I am financially responsible for all charges not covered by insurance.

PATIENT SIGNATURE:	DATE: