St. Anthony's

Dr.'s Brian & Gary Peterson

Vascular Surgery New Patient Form

Patient Information

Patient Name (First, MI, Last): ____

Birthdate (MM/DD/YY): ____

Primary Care Physician (PCP): ____

Referring Physician (This may be the same as your PCP): ____

Reason for Visit: ____

Medications (List prescription meds & over-the-counter meds. Type 'None' if you do not take any medications):

____

____

Allergies (List reaction if known. Type 'None' if you do not have any drug/food allergies):

____

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PAST MEDICAL AND SURGICAL HISTORY

Past Medical History:

☐ High Blood Pressure	☐ High Cholesterol	☐ Thoracic Aortic Aneurysm	☐ Arrhythmia
☐ Coronary Artery Disease	☐ Heart Attack/MI	☐ Abdominal Aortic Aneurysm	☐ Stroke
☐ Congestive Heart Failure	☐ Seizures	☐ Varicose Veins	☐ PVD
☐ Pulmonary Embolus	☐ clotting Disorder	☐ Emphysema/COPD	☐ DVT
☐ Asthma	☐ Pneumonia	☐ Diabetes	☐ Prostate Problems
☐ Kidney Disease	☐ Dialysis	☐ Urinary Tract Infection	☐ Cancer
☐ Liver Disease	☐ GERD	☐ Depression	☐ Anxiety
☐ Other Psychiatric Illness	☐ Other: ______________________________		

Surgeries /Hospitalizations (List operations and approximate dates):

____

____

SOCIAL/PERSONAL HISTORY

Tobacco Use: ☐Yes/Current ☐Former ☐No/Never

Tobacco Details (Type/Frequency/Quite Date): ____

Alcohol Use: ☐Yes/Current ☐Former ☐No/Never

Alcohol Details (Type/Frequency/Quite Date): ____

Illegal Drug Use: ☐Yes/Current ☐Former ☐No/Never

Illegal Drug Details (Type/Frequency/Quite Date): ____

Employment: ☐Employed ☐Retired ☐Disabled ☐Unemployed

Employment Details (Current Job/ Type of Work): ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

FAMILY HISTORY (Please list medical problems and cause of death if applicable):

Father: ______________________________ Mother: ______________________________

Siblings: ____

REVIEW OF SYSTEMS (ROS) (Please check all that apply):

Constitutional

☐ Fatigue ☐ Fever ☐ Recent Weight Change

Gastrointestinal

☐ Nausea/Vomiting ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea

Eyes

☐ Eye Disease ☐ Wear Glasses/Contacts ☐ Blurry/Double Vision

Ears/Nose/Throat

☐ Hearing Loss ☐ Change in Voice ☐ Ringing in Ears

Genitourinary

☐ Frequent Urination ☐ Blood in Urine ☐ Impotence

Cardiovascular

☐ Palpitations ☐ Chest Pain/Tightness ☐ Syncope/Fainting

Respiratory

☐ Chronic Cough ☐ Shortness of Breath ☐ Wheezing

Neurological

☐ Seizures ☐ Paralysis ☐ Numbness/Tingling ☐ Headaches

Musculoskeletal

☐ Arthritis ☐ Back Pain

Vascular

☐ Leg Pain with Walking ☐ Pain in Toes at Rest

Skin

☐ Rashes ☐ Lesions/Wounds

Psychiatric

☐ Memory Loss ☐ Depression/Anxiety

Thank you for taking the time to fill out this form. If you have any questions prior to your appointment, please call our office at (314) 525-4325.

Regards,
St. Anthony's Vascular Surgery Office