



New Patient Specialty Intake Form Division of Vascular Surgery

GIVING LIFE TO POSSIBLE

This form contains questions specific to the Department of Surgery-
Division of Vascular Surgery. If you are new to Baylor College of Medicine
and have not been seen in any of our offices, please be sure to complete our **New Patient
General Intake Form** along with this form. The General Intake Form is available at this office or
online through our interactive web site, My Chart.

Name _____ Date of birth _____ Today's Date _____

CARE TEAM

Referring Physician _____ Specialty _____ Phone _____

Primary Care Physician _____ Phone _____

Cardiologist _____ Phone _____

REASON FOR VISIT

PAIN ASSESSMENT

Are you having any pain? Yes No

If you are in pain, how strong is your pain? Please circle a single number.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

How long have you had your pain? _____

Where do you feel pain? _____

Is your pain in one spot or spread out? _____

How does the pain feel? Aching Cramping Gnawing Heavy Hot or burning

Sharp Shooting Stabbing Tender Throbbing Tiring or exhausting

Is your pain constant or does it come and go? _____

What activities make pain worse or improve it? _____

Does your pain limit what you can do? _____

How often does the pain occur and how long does it last? _____

Does anything trigger the pain? _____

Patient Name _____ Date Of Birth _____

SOCIAL HISTORY

Please state your marital status _____

Number of children _____

Are you retired/disabled/unemployed/employed? _____

Please state your most recent occupation _____

Please state your chief support person name _____

Drug use Current Former Never Chronic Social

If you answered anything besides "Never" please write down what you use/used, the frequency and date you quit. _____

MEDICATION INFORMATION

Date Started	Medication	Dose(mg)	Frequency	Given for:
___/___/___				
___/___/___				
___/___/___				
___/___/___				
___/___/___				
___/___/___				
___/___/___				

Herbs, Over the Counter medications _____

Are you currently taking 6 or more medications? Yes No

Are you currently taking any blood thinners or anti-coagulation? Yes No

Are you currently taking depression medication? Yes No

FAMILY HISTORY

Please list the specific disease and the person's family relation (include brothers, sisters, parents, grandparents, aunts, uncles, children)

Condition	Family Member	Age	Condition	Family Member	Age
Stroke			Tuberculosis		
Heart Attack			Mental Health		
Cardiac Bypass			Other		