



DEPARTMENT OF SURGERY
Vascular Consultation
History and Physical
INITIAL VISIT

Date: _____

PRINT OR USE PATIENT LABEL

Patient Name _____
Last First

MR # _____

DOB _____

PATIENTS, PLEASE FILL IN PAGES 1 - 2 WITH EXCEPTION OF SHADED AREA

New Patient (99201 - 99205)
 Established Patient (99211 - 99215)
 Office Consultation (99241 - 99245)

Age: _____ Sex: Male Female

Requesting Physician: _____

Primary Physician: _____

Other Specialists: _____

Reason for Visit (Chief Complaint): _____

Duration of Problem: _____ weeks _____ months _____ years _____ unsure

Are you having pain? Yes No

Pain Rating on 0 - 10 Scale: _____ (0 = No Pain; 10 = Worst Pain)

Location of Pain: _____ Is Pain: New Chronic

LBP	RBP	HR	RR	TEMP / ROUTE	HT	WT	BMI
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Mr. / Ms. _____ accompanied me today on this doctor's visit.

History of Present Illness: _____

PAST MEDICAL HISTORY (Please check all that apply):

<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis (Type: A B C D E or G)	<input type="checkbox"/> Transient Ischemic Attacks (mini stroke)
<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Cancer (type: _____ / treatment _____)
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Valve Problems / Murmur	<input type="checkbox"/> Emphysema / COPD
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Bleeding / Clotting Disorders	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> Raynaud's Syndrome
<input type="checkbox"/> Other, please list _____	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Irregular Heart Beat
	<input type="checkbox"/> Kidney Failure / Dialysis	<input type="checkbox"/> Crohn's Disease

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SOCIAL HISTORY:

Tobacco Use: # of Years smoking: _____ # of packs per day: _____ Date you quit: _____

Alcohol Use: # of Drinks per week: _____ Street Drugs: _____

Previous / Current Occupation: _____

Residence: I live alone I live with _____

Nursing Home Name _____ Telephone _____

Person / persons we may speak with regarding your medical condition:

Name _____ Phone number _____ Relationship _____

Name _____ Phone number _____ Relationship _____

FAMILY HISTORY (Check all that apply to your immediate family):

- Heart Disease Diabetes Stroke / Carotid Disease Lung Disease
- Blood Vessel Problem Bleeding / Clotting Disorder High Blood Cholesterol Aneurysms
- Varicose Veins Cancer (list all types) _____

REVIEW OF SYSTEMS (Please check any symptoms you currently experience):

GENERAL

- Fever / Chills
- Other _____

HEENT

- Change in Vision
- Dentures: Partial Full
- Hoarseness
- Change in Voice
- Other _____

CARDIOVASCULAR

- Palpitations
- Chest Pressure / Pain
- Swelling in Legs
- Cramping in Legs / Buttocks while Walking
- Sores on Legs / Feet that do not or are slow to heal
- Pain in your Toes / Feet at night that wakens you
- Varicose Veins
- Transient color changes and pain in your hands / feet

GASTROINTESTINAL

- Constipation
- Diarrhea
- Abdominal Pain Associated with Meals
- Unexplained Weight Loss

GENITOURINARY

- Impotence

MENTAL HEALTH

- Depression
- Anxiety
- Recovering Alcoholic / Substance Abuser
- Other _____

SKIN

- Skin Condition (describe) _____

RESPIRATORY

- Shortness of Breath
- Daily Cough
- Home Oxygen

NEUROLOGIC

- Dizziness
- Headache
- Passing Out
- Temporary loss of vision in one eye
- Difficulty speaking, slurring of words
- Temporary weakness / numbness of one arm / leg
- Migraines
- Decreased sensation in feet

HEMATOLOGIC

- Clotting Bleeding / Disorder
- Other _____

Additional Symptoms: _____

Reviewed By _____ Date _____

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PHYSICAL EXAM:

Constitutional: No Acute Distress Other: _____

Eyes: EOMI PERRLA Conjunctiva Pink
Sclera: Anicteric Icteric Other: _____

Ear, Nose, Throat: Assessment of Hearing: Normal Abnormal: _____
Oropharynx: Normal Abnormal: _____

Neck: Thyroid: Normal (no masses, tenderness, enlargement, or bruit) Abnormal: _____
 Trachea Midline

Lymphatic: Normal (no Lymphadenopathy of the head, neck, axillae, or groin) Other: _____

Breast: Defer Normal (no masses, nipple discharge, dimpling, or asymmetry) Other: _____

Integument: Normal Other: _____ **Diagram Of:** _____
 Wound / Incision: _____

Respiratory: Normal (clear to auscultation, ease of effort, symmetric expansion)
 Abnormal: _____

Cardiovascular: Heart Sounds:
 Normal (RRR, S1S2, no murmur, rug, or gallop)
 Abnormal: _____

Edema: No Yes: _____

Varicosities: No Yes: _____ Other: _____

PERIPHERAL PULSE EXAM (Please circle):

	Right				Left				Comments
Carotid:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Bruit:	Y	N			Y	N			
Radial:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Dop:	mono	biph.	triph.		mono	biph.	triph.		
Femoral:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Dop:	mono	biph.	triph.		mono	biph.	triph.		
Bruit:	Y	N			Y	N			
Popliteal:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Dop:	mono	biph.	triph.		mono	biph.	triph.		
Dorsalis Pedis:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Dop:	mono	biph.	triph.		mono	biph.	triph.		
Posterior Tibula:									
Pulse:	abs	dim	nl	prom	abs	dim	nl	prom	
Dop:	mono	biph.	triph.		mono	biph.	triph.		

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Date: _____

Graft Assessment:

Graft: _____

Pulse: abs dim nl prom Dop: mono biph. triph.

Graft: _____

Pulse: abs dim nl prom Dop: mono biph. triph.

Abdomen: Normal (no masses, tenderness, thrills, or pulsations) Other: _____

Genitourinary: Defer Other: _____

Musculoskeletal: Steady Gait Normal Strength Other: _____

Neurologic: Alert / Oriented x 3: No Yes CN Grossly Intact: No Yes Sensation Intact: No Yes

Other: _____

Psychiatric: Judgement Intact: No Yes Pleasant / Cooperative

Other: _____

LEVEL 1 Problem Focused (1 - 5)	LEVEL 2 Expanded Problem Focused (6+)	LEVEL 3 Detailed (2 each of 6 or 12 each of 2)	LEVEL 4 and 5 Comprehensive (2 each of 9)
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DIAGNOSTIC TESTING REVIEWED:

Vascular lab: Carotid Duplex Venous Duplex Lower extremity Abdominal ultrasound

Arteriogram: Aortogram with runoff Carotid arteriogram

Venogram: MRA CT Scan

Other: _____

DIAGNOSIS/ ASSESSMENT:

Cerebrovascular: Asymptomatic stenosis TIA CVA
Aneurysm: AAA Iliac Femoral Popliteal
Lower extremity: Claudication Rest pain Nonhealing ulcer
Venous: Varicose veins DVT Venous insufficiency Lymphedema

PLAN:

Vascular lab Arteriogram MRA CT Scan

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I saw and evaluated the patient. I agree with the findings and plan of care as documented in the recorder's note. My comments are as follows (Teaching physician must provide patient's customized information):

Total Visit Time _____ Minutes

Total Time Spent for Counseling and Coordination of Care _____ Minutes

(time may determine the level of service when this dominates more than 50% of the visit)

- Films / Studies reviewed in detail with patient
- Explained Surgical Options
- Medication Education
- Explained alternatives, benefits, and risks
- Discussed Post-Op Care
- Patient questions were answered

Issues Discussed with Patient: _____

Total Visit Time:	New Patient (99201-5):	10 / 20 / 30 / 45 / 60 minutes
	Consultation (99241-5):	15 / 30 / 40 / 60 / 80 minutes

Teaching Physician Signature: _____

Resident or Fellow Signature: _____

Nurse Practitioner / Physician Assistant: _____

Letter dictated to referring MD _____ Phone call to referring MD _____