Rex Vascular Specialists
4414 Lake Boone Trail, Suite 108 Raleigh, NC 27607
P: 919-784-2300 F: 919-784-2301

Patient Information

Last Name______________________________ First Name___________________________ M.I_____

Sex □M □F Date of Birth ___________________ Social Security #_______-________-________

Street Address ____

City_______________________________ ST___________ Zip Code_______________

Home Phone ( ) ________-_________ Cell Phone ( ) ________-__________

Alternate Phone ( ) ________-_________ Email ______________________________________

Marital Status: □Single □Married □Divorced □Widowed □Separated

Employment: □Full Time □Part Time □Not Employed □Self Employed □Retired □Military

Language: □English □Spanish □Other________________ □Need Interpreter

Ethnicity: □Hispanic □Non Hispanic □Declined/Other

Race: □Asian □Black or African American □Native Hawaiian □White □Declined/Other

Emergency Contact

Name____ Date of Birth___________________

Contact Number ( ) ________-_________ Relationship to Patient _________________________

Protected Heath Information Communication

Occasionally we will need to contact you to discuss your confidential protected health information. Below is a list of potential ways for us to communicate this information with you. Please check below to indicate your preferences in how we communicate your protected health information.

I give permission to call and leave a message with:

____Home Phone number

____Cell Phone number

____Work Phone number

____Employer/School

____Spouse/Parent

Power of Attorney/ Living Will

Do you have a Healthcare Power of Attorney and/or a Financial Power of Attorney? □Yes □No

Name: ____________________________________ Relationship: ____________ □Healthcare □ Financial

Phone Number: ( ) ________-_________ □Home □Work □Cell

Do you have a living will? □Yes □No

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Physician Information

Were you seen in Rex Hospital by a RVSS Physician? □Yes □No

If No, Who referred you to Rex Vascular Surgical Specialists? ___________________________________

Name of Practice: ____

Practice Phone Number: ( ) ________-_________

Other Physicians involved in your care:

____ ____

____ ____

Primary Care Physician:_______________________________________ ( ) ________-__________

Person Accompanying a Minor

First Name: ____________________________ Last Name: ____________________________ MI:_____

DOB:______________ Relationship to patient: ___________________ SSN: ______-______-_________

Street Address____

City______________________________ ST_________ Zip Code_______________

Home Phone ( ) ________-_________ Cell Phone ( ) ________-__________

Authorization

By signing below, I am authorizing Rex Vascular Surgical Specialists to release my medical records to my referring doctor, my primary care doctor and to any doctor I listed as being involved in my care. To file claims for all services provided to me; to determine whether I am eligible for insurance coverage and it the treatment/care is authorized for payment by my insurance or public benefits.

I verify that the above information is relevant and accurate to the best of my knowledge.

________________________________ ________________________________ _________________
Patient Signature Authorized Representative Date

____________________________________ _______________
Witness Date

On behalf of all coworkers at Rex, we hope you received excellent care. Our goal is always to provide you with excellent service.

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What is the reason for your visit today? ____

Personal/Medical History

Please check off any that you have had in the **past**.

Abdominal Aortic Aneurysm		Diabetes		Kidney Failure	
Alcoholism		Diverticulitis or Diverticulosis		Liver Disease	
Alzheimer's Disease		Emphysema		Mitral Valve Prolapse	
Anemia		Fibromyalgia		Osteoporosis	
Angina		Gout		Parkinson's Disease	
Arthritis		Headaches		Pnuemonia	
Asthma		Heart Attack		Reflux	
Blood Clot in Leg or Lung		Heart Murmur		Seizures	
Bronchitis		Hemorrhoids		Sickle Cell Disease	
Coronary Artery Disease		Hepatitis		Stroke	
Cancer ____________________		High Cholesterol		Thyroid Problem	
Cardiac Catheterization		HIV/AIDS		Transplant	
Cirrhosis		High Blood Pressure		Tuberculosis	
Colon Polyps		Irregular Heart Beat		Ulcer	
Depression		Irritable Bowel Syndrome		Other _____________________	

Please check off any that you are experiencing **now**.

Abdominal Bleeding		Diarrhea		Numbness__________________	
Abdominal Pain		Double Vision		Painful Breathing	
Arthritis		Enlarged Lymph Nodes		Painful Urination	
Bleeding Easily		Fatigue		Rash	
Bloody Urine		Fever		Recent Cold	
Breast Discharge		Headache		Rectal Bleeding	
Breast Pain		Hearing Loss		Shortness of Breath	
Change in Stools		Heartburn		Sinus Congestion	
Chills		Hoarseness		Sore Throat	
Chronic Cough		Insomnia		Sweats	
Constipation		Irregular Heart Beat		Swelling in Feet	
Coughing up Blood		Jaundice		Tingling ___________________	
Coughing up Phlegm		Joint Pain		Trouble Swallowing	
Decreased Appetite		Loss of Vision		Vomiting	
Depression		Nausea		Weight Loss	
		Nosebleeds		Wheezing	

Please list all medical problems in your family. Family Member/Issue

Family Members with Cancer □Yes □No Family Member/Type of Cancer

Do you live in a Retirement or Nursing Home? □Yes □No If yes, Name and Number-

____ ( ) ________-__________

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Do you live □alone □with spouse □with family □with others ________________

Do you feel safe in your home? □Yes □No

Are you currently receiving Home Health Services? □Yes □No

Do you wear: □Glasses □Contacts □Hearing Aids □N/A

Do you use: □Cane □Walker □Wheelchair □Artificial Limb □N/A

Do you smoke □Cigarettes ______Pks per day ____Yrs □Cigars □Pipe □N/A

Did you smoke □Cigarettes ______Pks per day ____Yrs □Cigars □Pipe □N/A

Do you drink alcohol? □No □Occasionally □Daily □In the past occasionally □In the past Daily

Do you have a Pace Maker? □Yes □No If Yes, Type: ______________________________________

Do you have an AICD? □Yes □No If Yes, Type: ______________________________________

Allergies/Reactions: ____

Are you allergic to Latex? □Yes □No

Medications	Dose (mg)	Frequency

Pharmacy:____ ( ) ________-_________

Surgical Procedures	Date (MM/YYY)

Do you have someone to help you recover from surgery or medical treatment? □Yes □No

Are you currently receiving dialysis? □Yes □No

If yes, please answer the following:

Dialysis Days: □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday

Dialysis Center: ____

Nephrologist: ____

Previous access sites? □Yes □No If yes, where? ____