RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • Phone: (860) 409-1952 • Fax: (860) 409-1942
Enfield • Phone: (860) 714-9410 • Fax: (860) 714-9409
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Patient History & Physical Form

Patient Name: _____ **Age:** ___ **D.O.B.:** _____ **Visit Date:** _____
Referring/Consulting Doctor: _____ **Referring Doctor Phone:** _____
Primary Care Doctor _____

Reason for visit: Please list when condition started; is it better or worse now and what tests/treatments have been done? Any new medication started?

_____
_____
_____
_____
_____

If here for Spider Vein or Varicose evaluation please fill in areas below and section on Vein Disease – page 2.

If you have pain, please describe:
Location: _____
Timing: (continuous, occasional, episodic)
_____
Duration: (min/hrs, a.m./p.m.) _____
Quality: (ache, sharp, dull, burning, tiredness, cramp, tender, throbbing, numb, stabbing)
_____
What makes it worse/better? _____
_____
Rate Severity mild (1) – severe (10)_____

Past Medical History

High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No	Collapsed lung	Yes	No
Neuropathy	Yes	No	Emphysema/COPD	Yes	No			
Heart Problems	Yes	No	Cancer	Yes	No			
Heart Attack/MI	Yes	No	Bleeding? Ulcer?	Yes	No			
Heart Failure/CHF	Yes	No	Aneurysm	Yes	No			
Stroke/CVA/TIA	Yes	No	DVT/Blood Clot	Yes	No			
High Cholesterol	Yes	No	Varicose Veins	Yes	No			

List Any Other Medical Problems

_____
_____
_____
_____
_____
_____

Past Surgical History

Check items listed and please list **ALL** other types and **WHEN**:

Heart bypass _____
Leg bypass R/L _____
Vein Surgery R/L _____
Carotid Surgery R/L _____
Aortic Aneurysm _____

Hernia
Gallbladder
Thyroid
Other _____
_____

Has anyone in your family ever had...	Father	Mother	Bro/Sis
Cancer			
Diabetes			
Hypertension			
Heart Problems			
Aneurysms			
Stroke			
Varicose Veins			

Social History

Alcohol Yes No If yes, how much? _____
Tobacco Yes No Stop when? _____
If yes, how much? _____
Do you live alone? Yes No
Work Type _____

Provide List of **All Medications** and **Dose** you are currently taking – including all natural supplements.

_____
_____

Med Allergies: **Pain Meds:**

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Review of Systems: Please circle all that apply

Constitutional: fever, chills, weight loss/gain – lbs. _____
Skin: ulcers, rash, itching, cellulitis, melanoma, basal cell cancer, squamous cell cancer
Eyes: temporary loss of vision in one eye, blurred vision, cataracts, glasses
ENT: dentures, ear problems, hearing aid, nose bleeds, congestion, swallowing problems
Cardiac: chest pain, angina, chest pain with exertion, palpitations, leg swelling, ankle swelling
Respiratory: short of breath (SOB), wheezing, SOB when lie flat
GI: nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stools
GU: frequency, urgency, burning when urinate, prostate problems, kidney disease
Musculoskeletal: pain legs/calf while walking, sciatica, back pain, back disc disease, joint pain
Neurologic: dizzy, lightheaded, weak or numb one side – arm/leg/face, headache, pass out
Psych: depression, anxiety, psychosis, rehab for drug or alcohol abuse
Endocrine: excessive thirst or urination, thyroid disease
Heme/Immune: HIV/AIDS, Hepatitis A, B, C, allergies, easy bruising, clotting disorder

Varicose Veins/Spider Veins: **If you are here for this condition,** please circle all that apply

1. Do you experience any of the following?
   a. Aching pain in your legs..... Yes No
   b. Heaviness..... Yes No
   c. Tiredness/fatigue ..... Yes No
   d. Itching/burning..... Yes No
   e. Swollen ankles..... Yes No
   f. Leg cramps..... Yes No
   g. Restless legs..... Yes No
   h. Throbbing..... Yes No
   i. Other _____
2. Have your veins worsened in recent months? ..... Yes No
3. Do you elevate your legs to relieve discomfort? ..... Yes No
4. Do you, or have you used any type of support/compression hose?..... Yes No
5. Do they provide relief?..... Yes No
6. Are you taking any pain medicine? ..... Yes No
   a. What type and how often? _____
7. Are you taking any iron supplements or vitamins with iron? ..... Yes No
8. Have you ever had your veins evaluated before?..... Yes No
   a. If so, when and where? _____
9. Have you ever had a superficial vein or varicose vein blood clot, phlebitis?..... Yes No
10. Have you ever had a deep vein thrombosis? ..... Yes No

Blood Pressure: _____ Pulse: _____

Notes: _____
_____
_____
_____

Patient Name: _____ Hx reviewed with patient Initials _____