



RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street
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Phone: (860) 969-6400

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Patient History & Physical Form

Patient Name: MR#: D.O.B.:

Visit Date: Referring Physician:

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 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)

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

What makes it worse/better?

Rate Severity mild (1) - severe (10)

Past Medical History

List Any Other Medical Problems

Table with 3 columns of medical conditions and Yes/No checkboxes. Includes High Blood Pressure, Diabetes, Neuropathy, Heart Problems, Heart Attack/MI, Heart Failure/CHF, Stroke/CVA/TIA, High Cholesterol, Kidney Disease, Thyroid Disease, Emphysema/COPD, Cancer, Bleeding? Ulcer?, Aneurysm, DVT/Blood Clot, Varicose Veins, Seizures, Collapsed lung.

Past Surgical History

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

Table for surgical history with rows for 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 Sibling

Social History

Table for family history and social history. Includes rows for Cancer, Diabetes, Hypertension, Heart Problems, Aneurysms, Stroke, Varicose Veins, Alcohol, Tobacco, Do you live alone?, Work Type.

Physician Signature: Date/Time:



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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
b. Heaviness
c. Tiredness/fatigue
d. Itching/burning
e. Swollen ankles
f. Leg cramps
g. Restless legs
h. Throbbing
i. Other
2. Have your veins worsened in recent months?
3. Do you elevate your legs to relieve discomfort?
4. Do you, or have you used any type of support/compression hose?
5. Do they provide relief?
6. Are you taking any pain medicine?
7. Are you taking any iron supplements or vitamins with iron?
8. Have you ever had your veins evaluated before?
9. Have you ever had a superficial vein or varicose vein blood clot, phlebitis?
10. Have you ever had a deep vein thrombosis?

Blood Pressure: Pulse:

Notes:

Patient Name: Hx reviewed with patient (Initials):

Physician Signature: Date/Time: