

R.V. RAO, M.D., M.S. (Surg) F.A.C.S., F.I.C.S.

Diplomate American Board of Surgery
General Surgery and Vascular Surgery

PATIENT REGISTRATION

DATE

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	
STREET ADDRESS		CITY STATE, ZIP	
PHONE (HOME)	(WORK)	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION
S. S. #	DRIVER'S LICENCE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I.D #	GROUP #
		BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
SUBSCRIBER'S NAME	I D #	GROUP #
		BENEFIT CODE
MEDICARE #	MEDICAID I D.#	
OTHER COVERAGE		

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. RAO, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. RAO, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE • MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf

A photocopy of these assignments shall be valid as the original.

PATIENT (please print)

DATE

PARENT / GUARDIAN (please print)

SIGNATURE

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INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination

TODAY'S DATE _____

It will help your physician to know not only about your health but also about your family and relatives

NAME _____ ADDRESS _____

TELEPHONE NUMBER _____ DATE OF BIRTH _____ AGE _____ PLACE OF BIRTH _____ RACE OR NATIONALITY OF PARENTS _____

RELIGION _____ EDUCATION (highest level attained) _____ OCCUPATION ► _____ HOW LONG _____

PRESENT MARRIAGE (Year married) _____ PREVIOUS MARRIAGE (Year married and duration) _____

WHERE AND WHEN HAVE YOU LIVED OR TRAVELLED OUTSIDE THE U.S. AND CANADA? _____

FATHER ►	ALIVE	Present health or cause of death	MOTHER ►	ALIVE	Present health or cause of death	SPOUSE ►	ALIVE	Present health or cause of death
	DECEASED	CAUSE OF DEATH		DECEASED	CAUSE OF DEATH		DECEASED	CAUSE OF DEATH
BROTHERS ►	ALIVE	HEALTH	SISTERS ►	ALIVE	HEALTH	CHILDREN ►	ALIVE	AGES & HEALTH
	DECEASED	CAUSE OF DEATH		DECEASED	CAUSE OF DEATH		DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nervous illness	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Allergy	<input type="checkbox"/> Other						

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Bleeding tendencies
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Other				

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED _____

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?

No Yes ► LIST _____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

No Yes ► LIST _____

DO YOU USE TOBACCO NOW? IN THE PAST? TYPE AND DAILY AMOUNT HOW LONG?

No Yes No Yes _____ WEEKLY AMOUNT _____ HOW LONG? _____

DO YOU USE ALCOHOLIC BEVERAGES? TYPE WEEKLY AMOUNT HOW LONG?

No Yes ► _____ WEEKLY AMOUNT _____ HOW LONG? _____

DO YOU DRINK COFFEE? WEEKLY AMOUNT HOW LONG?

No Yes ► _____ WEEKLY AMOUNT _____ HOW LONG? _____

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

Smallpox Tetanus Typhoid Polio Influenza Other _____

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon) _____

DENTAL (List any problems you have now) _____

MEDICATIONS (Name or otherwise identify medicines now or recently used) _____

ONSET DATE OF LAST MENSTRUAL PERIOD PERIODS ARE NUMBER OF PREGNANCIES NUMBER OF MISCARRIAGES

Regular Irregular _____

HAVE YOU TAKEN CORTISONE TYPE DRUGS? ORAL CONTRACEPTIVES? HAVE YOU RECEIVED A BLOOD TRANSFUSION?

No Yes No Yes No Yes ► DATE _____

DRESSED WEIGHT HOW LONG HAVE YOU BEEN AT THIS WEIGHT? _____

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT? _____

WHAT IS YOUR MAIN SYMPTOM? _____

REVIEWED BY (Physician) _____ DATE _____

Vascular Clinic

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-----TO BE FILLED OUT BY PATIENT-----

Past Medical Illness

	YES	NO
1. Have you had any surgery on your arteries? If yes, describe _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have high cholesterol level?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you have clots in your veins?	<input type="checkbox"/>	<input type="checkbox"/>
8. Were you treated for clots in your lungs?	<input type="checkbox"/>	<input type="checkbox"/>

Family History

Any of your family (grandparents, parents aunts, uncles, mothers, sisters) had the following conditions? (circle)

Same Condition Diabetes Vascular Problems Gangrene Amputation Stroke
 High Blood Pressure Heart Problems Heart murmur Clotting Problems Bleeding Problems
 Cholesterol Problems

History of Present Illness

1. What is your main complaint?

Extremities

2. Do you have any of the following in your legs feet, arms, or fingers?

	YES	NO
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold	<input type="checkbox"/>	<input type="checkbox"/>
Numb/Sensitive	<input type="checkbox"/>	<input type="checkbox"/>
Discoloration	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Ulceration	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

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- | | YES | NO |
|--|--------------------------|--------------------------|
| 9. Did you have tingling/loss of sensation/temporary numbness/ weakness/paralysis/clumsiness in one side of the body lasting a few minutes or hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have temporary slurring of speech lasting a few minutes or hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Did your mouth droop or you had difficulty talking for a few minutes or hours? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Did you have any temporary blackout in your eyesite? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Did you have any change in your vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you fainted? | <input type="checkbox"/> | <input type="checkbox"/> |

Visceral

- | | YES | NO |
|---|--------------------------|--------------------------|
| 15. Have you had problems with your sexual life?
<i>If yes, circle the problem.</i>
Failure of erection, inability to perform sex, failure of ejaculation, dry ejaculation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you get pain after eating food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have back pain? | <input type="checkbox"/> | <input type="checkbox"/> |

Venous

- | | | |
|---|--------------------------|--------------------------|
| 18. Do you get pain in your legs on standing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does you ankle swell at the end of the day? | <input type="checkbox"/> | <input type="checkbox"/> |

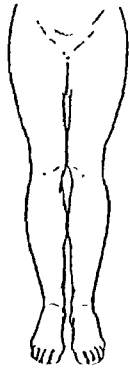
Vascular Clinic

1. Do you get a pain or discomfort in your leg(s) when you walk?
YES **NO** **I AM UNABLE TO WALK**

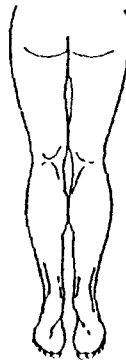
If you answered "Yes" to question 1-please answer the following questions. Otherwise proceed to question 7.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 2. Does this pain ever begin when you are standing still or sitting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you get it if you walk uphill or hurry? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you get it when you walk at an ordinary pace on the ground level? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What happens to it if you stand still? | | |
| Usually continues more than 10 minutes | <input type="checkbox"/> | <input type="checkbox"/> |
| Usually disappears in 10 minutes or less | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Where do you get this pain or discomfort? | | |
| Mark the place(s) with "x" on the diagram below. | | |

Front



Back



7. Do you get pain/discomfort on exercising or using your arm/hand?
 Do you get pain in lower extremity while walking?

If yes, answer the following questions.

- a. How long can you walk without pain?
- b. Do you have to stop when you get pain?
- c. Does the pain get relieved on resting?
- d. Is the located in the: Thigh, Calf, Ankle, Foot (circle one)

CNS

8. Do you have temporary attacks of
- | | | |
|------------------|------------------------------|-----------------------------|
| dizziness? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| loss of balance? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| unsteadiness? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| double vision? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

STUDY OF SYSTEMS

Check (✓) either, yes or no for each item except where applies to only male or female

Conditions		✓	No	Conditions		✓	No	Conditions		✓	No	
GENERAL HEAD	Fever			NECK	Stiffness			PSYCHOLOGICAL	Is Your Life:			
	Chills				Swelling				Satisfactory			
	Bruise Easily				Lumps				Boring			
	Swollen Glands				Other*				Demanding			
	Loss of Memory				Appetite Poor				Unsatisfactory			
	General Weakness				Indigestion/Heartburn				Is There Worry Over:			
	Aches/Pains				Nausea				Home Life			
	Double Vision				Vomiting Blood				Marriage			
	Light Flashes				Abdominal Pain or Cramps				Job			
	Blurred Vision w/o Glasses				Abdominal Tension				Children			
GENERAL HEAD	Halos Around Lights			GASTROINTESTINAL	Diarrhea			Money				
	Eye Pains				Constipation			Do You:				
	Ear Pains				Bowel Habit Changes			Often Feel Depressed				
	Ear Drainage				Rectum Blood Passage			Have Irrational Fears				
	Buzzing/Ringing in Ears				Black Tar-Type Bowel Movements			Feel Upset				
	Nosebleeds				Other*			Feel Things Often Go Wrong				
	Sinus Problems				Up Nights to Urinate			Feel Shy				
	Swallowing Problems				Blood in Urine			Cry Easily				
	Deafness				Burning or Pain While Urinating			Feel Inferior				
	Mouth, Tooth or Tongue Problems				Problem Passing Urine			Have You:				
GENERAL HEAD	Persistent Hoarseness			KIDNEY	Trouble Controlling Urine			Attempted Suicide				
	Severe Headaches				Other*			Seriously Considered Suicide				
	Other*				Leg or Arm Weakness			Lump in Testicles				
	Rash				Balance Problems			Penis Discharge				
	Changing Moles				Dizziness			Breast Lump				
	Pigmentation				Fainting Spells			Sore on Penis				
	Other Skin Problems*				Speech Problems			Erection Difficulties				
	SKIN	Irregular Heartbeat				NEUROMUSC	Other*			Other*		
		Shortness of Breath					Joint Pains			Breast Lump		
		Low Exercise Tolerance					Joint Swelling			Nipple Discharge		
Heart Flutters				Muscle Strength Loss				Vaginal Discharge				
Chest Pains				Muscle Lump or Swelling				Non-Period Bleeding/Spotting				
Frequent Coughs				Lump on Bone				Hot Flashes				
Cough up of Blood				Pains in Back				Pain with Intercourse				
Wheezing				Other*				Possibly Pregnant				
Night Sweats				Constant Thirst				Change in Periods				
Swollen Ankles				Most Always Cold				Pain Other Than With Periods				
CHEST HEART LUNGS	Cramps in Legs			BONES JOINTS	Too Warm Most Times			Other*				
	Other*				Very Sluggish or Tired							
					Jumpy/Nervous							

Explain Other*

Doctor's Use Only — Summary