NEPA VASCULAR

Welcome to NEPA Vascular!

Our Center is staffed with a team of physicians, nurses, and therapists specializing in vascular care, hyperbaric medicine and advanced wound management. Our Center provides quality medical care that is easily accessible and responsive to you in your time of need.

We value you as a patient and will strive to provide you with exceptional medical care. Our comprehensive approach can promote healing, relieve pain, optimize your nutrition, and help improve your overall quality of life. As you progress through your treatment plan, we will keep you informed, ensuring that you understand the planned course of treatment and what is expected of you. Our team will also provide educational information to help you gain a greater understanding of your condition.

Please fill out the enclosed forms. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process.

Please let us know if there is anything we can do to make your experience at NEPA Vascular Institute more pleasant.

Thank you for choosing us as your provider.

Warmest Regards,

NEPA Vascular Institute Patient Care Team

1918 W Front Street
Berwick, PA 18603
Phone:570-616-8589 | Fax:570-616-8590

John A. Guerriero III, DO
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Patient Medical History Form

PLEASE NOTE: PROVIDERS AND STAFF ARE NOT RESPONSIBLE FOR MISINFORMATION OR INFORMATIONTHATISNOTDISCLOSED.PLEASECOMPLETEALLSECTIONSOFTHISFORM.

Name:_____ DOB:____/____/___

Primary Care Physician: _____ Referred By : _____

Reason for Visit: _____

Medical History					
Check **ONLY** those that apply					
☐	ADHD/ADD	☐	Ear Problems	☐	Osteoporosis
☐	Allergies	☐	Excessive Perspiration	☐	Parathyroid Disease
☐	Anemia/Blood Disorder	☐	Eye Problems	☐	Peripheral Disease
☐	Aneurysm	☐	Gastrointestinal Bleeding	☐	Pleurisy
☐	Anxiety Disorder	☐	Head Trauma/Injury	☐	Pneumonia
☐	Arthritis	☐	Headaches	☐	Pulmonary Embolism
☐	Atherosclerosis	☐	Heart Disease	☐	Radiation/Chemo
☐	Back/Neck Problems	☐	Heartburn/Reflux	☐	Rheumatic Fever
☐	Bladder or Kidney Problems	☐	Hepatitis/Liver Disease	☐	Skin Problems
☐	Blood Clots/DVT	☐	Concussion or Spinal Trauma	☐	Sleep Disorder
☐	Bowel Problems	☐	Dementia	☐	Stroke
☐	Bronchitis	☐	Herniated Disc	☐	Thyroid Disease
☐	CAD	☐	High Cholesterol	☐	Tuberculosis
☐	Cancer(Type:)	☐	HIV/AIDS	☐	Ulcers
☐	Cardiac Arrhythmia	☐	Hypertension	☐	Urinary/Bladder
☐	Carotid Blockage	☐	Kidney Disease	☐	Use of Blood Thinners
☐	Depression	☐	Lung Disorder/Disease	☐	Use of NSAIDS
☐	Diabetes	☐	Migraines	☐	Varicosities
☐	Dialysis	☐	Nephropathy	☐	VascularDisease
☐	Dizziness	☐	Nerve Disease		

Are you **RIGHT** handed or **LEFT** handed? (please circle)

Latex Allergy?	Yes or No	Iodine Allergy?	Yes or No

Please list ALL MEDICATIONS that you are currently taking (including over-the-counter medications, vitamins, and herbal remedies):		
NametheDrug	Strength	FrequencyTaken

Allergies to medications (please list)		
NametheDrug	Reactionto Medication	Onset Date

Preferred Pharmacy: _____

Where do you get your blood work done? _____

Surgical History or Hospitalizations (please list dates)		
Year	Reason	Hospital

List any recent (within the last year) x-rays, angiograms, ultrasounds, ultrasounds of neck (carotid), leg studies, pulmonary (lungs) etc.		
Year		

List any Cardiac Testing, Exercise Stress Test, Heart Catheterizations, Echocardiograms, etc.		
Year		

SOCIAL HISTORY			
Alcohol	Howoftendidyouhaveadrinkcontainingalcoholinthepastyear?		
	□Occasional/Social □Moderate □Heavy		
Tobacco	Doyouusetobacco?□Yes□No	SmokeCigarettes___#packs/day:	
	FormerSmoker □Yes□No	___#ofyears	
	____ Year quit		
Drugs	Doyoucurrentlyuserecreationalorstreet drugs?	□Yes	□ No
Drink:	Coffee	□Yes	□ No
	Tea	□Yes	□ No
	Soda	□Yes	□ No
	DECAF/Caffeine_____	□Yes	□ No
Marital Status	Married	□Yes	□ No
Employment	Employed?	□Yes	□ No
	Position:		
	Part/Full Time?		

FAMILY HISTORY		
Please check ALL that apply & list relationship		
□	Heart Disease	
□	Clot/DVT	
□	Stroke	
□	Vascular Problems	
□	Pulmonary Embolism	

Circle the following that apply to you:

Do you have discomfort in your buttocks, thighs, calf, ankles, feet, right leg, left leg, both legs whenwalking? **Yes or No**

Do you have any sores or color changes on your feet? **Yes or No**

Do you have discomfort in your feet while you sleep? **Yes or No**

Have you ever had full or partial loss of vision in one or both eyes? **Yes or No**
Whicheye?**Right Left Both**

Have you ever had weakness, tingling, numbness or clumsiness in your face, arms, or legs? **Yes or No**

Have you ever had difficulty speaking, been unable to speak, or had trouble finding words? **Yes or No**

Consent

I approve my Physician/Provider/Nurse/Staff to leave NORMAL test results on my answering machineorvoicemail? **Yes or No**

If I am not available to receive my test results, I authorize you to release this information to:

_____

☐ I do NOT wish you to report any results to anyone other than myself (check the box)

Signature of patient/authorized person: _____ Date: ____/____/____

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NEPA VASCULAR NO SHOW POLICY

Here at NEPA Vascular, our number one priority is patient care. We would like to be available for our patients and be able to offer them appointments when they are needed and as fast as we can.

We do REQUIRE 24-hour notice for cancellations of ANY appointment. The reason for this is to be able to offer that appointment time to a patient who needs to be seen as we are able to see them faster.

PLEASE NOTE: There will be a $40.00 charge for ANY appointment that you are considered a "no-show" for. A "no-show" is when you fail to present to the office for your scheduled appointment or you do not call 24 hours prior to your scheduled appointment to cancel or reschedule.

Our priority is you! Thank you for understanding!

Patient Signature: _____ Date: ____/____/____