

John D. Horowitz, M.D., F.A.C.S.
Board Certified, Vascular Surgery
Diplomate of the American Board of
Venous and Lymphatic Medicine

Jason B. Carter, PA-C
Physician Assistant



Harry Agis, M.D., F.A.C.S
Diplomate of the American Board of Surgery
Diplomate of the American Board of Venous
and Lymphatic Medicine

Paige Mackenzie, PA-C
Physician Assistant

Welcome to our Practice!

Please completely fill out the enclosed patient information forms and bring the **completed** forms to our office on your appointment date. Completing these forms in their entirety **prior** to your appointment will help your appointment to run more smoothly.

Also, please remember to bring a **PHOTO ID**, your **INSURANCE CARD(S)**, **COPAY**, and a **COMPLETE LIST OF YOUR MEDICATIONS** (including the medication name(s), dosages and how often you take them).

Should you have any questions please feel free to call our office. Thank you and we look forward to seeing you!

Sincerely,

**Surgical Specialists of Central Florida
Central Florida Vein & Vascular Center**

**JOHN D. HOROWITZ, M.D.
HARRY AGIS, M.D.**

Patient Name <i>(Nombre del Paciente)</i>		DOB <i>(Fecha de Nacimiento)</i>	SS# <i>(Seguro Social)</i>	Sex <i>(Sexo)</i>	Marital Status <i>(Estado Civil)</i>
Ethnicity <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Not Reported/Refused					
Select Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Subcontinent Asian American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian Pacific American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black Non-Hispanic <input type="checkbox"/> White Non-Hispanic <input type="checkbox"/> Other Race or Ethnicity					
Street Address <i>(Dirección)</i>				Home Phone <i>(Telefono De Hogar)</i>	
City <i>(Ciudad)</i>	State <i>(Estado)</i>	Zip Code <i>(Código Postal)</i>	Alternate Phone <i>(Otro Telefono)</i>	Cell Phone <i>(Numero De Celular)</i>	
Place of Employment <i>(Sitio de Empleo)</i>		Occupation <i>(Ocupacion)</i>		Work Phone <i>(Telefono de Su Trabajo)</i>	
Name of Spouse <i>(Nombre de su Esposo/Esposa)</i>			Email Address <i>(Dirección Electrónica)</i>		
Nearest Relative not living with you <i>(Familiar cercano que no viva con usted)</i>			Phone # <i>(Telefono)</i>		
Emergency Contact <i>(Contacto de Emergencia)</i>			Phone # <i>(Telefono)</i>		
Primary Insurance <i>(Seguro Primario)</i>		Subscriber's Name/DOB <i>(Nombre del Responsable/Fecha de Nacimiento)</i>		Policy ID# <i>(Numero de Poliza)</i>	Group # <i>(Numero de Group)</i>
Insurance Claims Address <i>(Dirección de la Compania de Seguro)</i>			Insurance Phone <i>(Telefono del Seguro Medico)</i>		
Secondary Insurance <i>(Seguro Secundario)</i>		Subscriber's Name/DOB <i>(Nombre del Responsable/Fecha de Nacimiento)</i>		Policy ID# <i>(Numero de Poliza)</i>	Group # <i>(Numero de Group)</i>
Insurance Claims Address <i>(Dirección de la Compania de Seguro)</i>			Insurance Phone <i>(Telefono del Seguro Médico)</i>		
Relationship to Patient <i>(Relacion al Paciente)</i>		If other than patient, Insured SS# <i>(Seguro Social del Responsable del Seguro)</i>		If other than patient, DOB <i>(Fecha de Nacimiento del Responsable)</i>	
Prescriptions are sent directly to your pharmacy. We will need the following information.					
Pharmacy Name <i>(Nombre de la Farmacia):</i>			Pharmacy Phone <i>(Telefono de la Farmacia):</i>		
Pharmacy Address <i>(Dirección de la Farmacia):</i>			Pharmacy Fax <i>(Faximile de la Farmacia):</i>		
Referred by: <input type="checkbox"/> Self <input type="checkbox"/> Internet <input type="checkbox"/> Television <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Other <input type="checkbox"/> Physician _____					
I authorize the Physicians and Physician's associates of Surgical Specialists of Central Florida to render medical care to the above named patient. I acknowledge that all information listed above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize release of any medical information necessary to process and insurance claim on my behalf. This signed agreement will act as a valid facsimile of the original.					
Patient's Signature _____ <i>(Firma del Paciente)</i>			Date _____ <i>(Fecha)</i>		

John D. Horowitz, M.D., F.A.C.S.
Board Certified, Vascular Surgery
Diplomate of the American Board of
Venous and Lymphatic Medicine

Jason B. Carter, PA-C
Physician Assistant



Harry Agis, M.D., F.A.C.S.
Diplomate of the American Board of Surgery
Diplomate of the American Board of Venous
and Lymphatic Medicine

Paige Mackenzie, PA-C
Physician Assistant

CANCELLATION OF APPOINTMENTS

OUR OFFICE REQUIRES A 48-HOUR NOTICE FOR CANCELLATION OF APPOINTMENTS. IF YOU FAIL TO GIVE OUR OFFICE A 48-HOUR NOTICE OR IF YOU DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, THERE WILL BE A \$50.00 CHARGE BILLED DIRECTLY TO YOU.

THANK YOU,
CENTRAL FLORIDA VEIN & VASCULAR CENTER

PATIENT'S NAME: _____

PATIENT'S SIGNATURE _____

TODAY'S DATE _____

John D. Horowitz, M.D., F.A.C.S.
Board Certified, Vascular Surgery
Diplomate of the American Board of
Venous and Lymphatic Medicine

Jason B. Carter, PA-C
Physician Assistant



Harry Agis, M.D., F.A.C.S
Diplomate of the American Board of Surgery
Diplomate of the American Board of Venous
and Lymphatic Medicine

Paige Mackenzie, PA-C
Physician Assistant

PRIVACY PRACTICE **ACKNOWLEDGEMENT**

I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW
THE NOTICE OF PRIVACY PRACTICES AND MAY ALSO
REQUEST A COPY TO KEEP FOR MYSELF IF I SO CHOOSE.

NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

ABOUT YOUR MEDICAL RECORDS

Information found in medical records is confidential. Healthcare workers are mandated by law and by professional standards to protect patient confidentiality. Your record is the physical property of Surgical Specialists of Central Florida Inc dba Central Florida Vein & Vascular Center. However, the patient controls the release of the information contained in the record.

In general, you must give permission for anyone, other than a member of your established healthcare team, to have access to your medical record. By law, your records may be disclosed without your permission under certain circumstances such as in response to a subpoena or court order, to certain government and regulatory bodies, to someone who holds your power of attorney, to someone you have designated as your healthcare surrogate, to another established healthcare provider for continued care, and to your healthcare insurer to obtain reimbursement for your care.

If you should need copies of your medical record for services received at Surgical Specialists of Central Florida Inc dba Central Florida Vein & Vascular Center, please contact our office. We will need **prior** notification, along with a properly executed Authorization to Release PHI (protected health information/medical Information) form before we can release any medical information, as there are specific Federal guidelines that we are required to follow. In addition, you will need to provide us with proof of identification (your driver's license or state ID), and after comparing your signature with the one we have on file, we will release the medical information that you are requesting. For your convenience, you may access the form from our website (www.cfvein.com).

In order for your power of attorney, healthcare surrogate or personal representative to obtain copies of your records, we must be provided a copy of the properly executed documents designating the individuals as such to keep in our files.

After receiving the properly executed form(s), copies will be available **for your pick up within seven working days**. This time frame allows us to conduct our research and ensures the availability of the requested information.

The records are generally burned to a CD in PDF file. Should you prefer your records in a different format, please indicate this at the time of request. There may be a nominal charge to offset the costs of providing your copies.

Health Central
10000 West Colonial Drive
Suite 495
Ocoee, Florida 34761

Kissimmee
3302 Greenwald Way North
Kissimmee, Florida 34741

The Villages
1503 Buenos Aires Boulevard
Suite 123
The Villages, Florida 32159

Fax: 407.293.7355 • 407.293.5944 • www.cfvein.com

Operating as: Surgical Specialist of Central Florida, Inc.

COMMUNICATIONS AGREEMENT

In order to keep pace with electronic communications and comply with governmental regulations, please let us know how you would like us to communicate with you.

PLEASE CHECK APPROPRIATE BOXES BELOW & INDICATE PRIORITY (1st, 2nd or 3rd) OF NUMBERS

Priority

Home Telephone # _____ - _____ - _____

OK to leave **voice** message with detailed information

Leave message with call back number only

Priority

Cellular Telephone # _____ - _____ - _____

OK to leave **voice** message with detailed information

Leave message with call back number only

OK to send text message (Opt In) Cell Phone Carrier _____

Priority

Work Telephone # _____ - _____ - _____

OK to leave **voice** message with detailed information

Leave message with call back number only

Email Address : _____

OK to send email message with detailed information

Written Communication

Mail will be sent to the home address provided to practice.

I agree and consent to the Practice releasing information to myself in the above manners.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Central Florida Vein & Vascular Center in writing. The revocation shall be effective *except* to the extent that Central Florida Vein & Vascular Center has already taken action in reliance on the Consent.

Patient Name: «PatientFullName» Date: _____

Signature: _____

**CONSENT TO USE OR DISCLOSE INFORMATION FOR
TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS
AND COMMUNICATION WITH FAMILY AND FRIENDS**

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (“protected health information”) and patient medical record information by Surgical Specialists of Central FL (the “Practice”) in order to carry out treatment, payment, or health care operations.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient’s requested restriction(s), such restrictions are then binding on the Practice.

Family and Friends. It is the office policy of Surgical Specialists of Central Florida not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not list anyone below, your medical information will not be released except as stated in this signed Consent. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing.)

Spouse: _____ Parent: _____
Other: _____ Other: _____
Other: _____ Other: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

- HIV/AIDS/Sexually Transmitted Diseases Drugs/Alcohol Mental Health

Signature: _____

At all times, Patient retains the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

«PatientFullName» _____ Signature of Patient (Authorized Representative*) _____ Date _____
Print Name

*Please explain Representative’s Relationship to Patient and include a description of Representative’s Authority to act on behalf of the Patient (Proof of authorization must be provided):

Name (Paciente): _____

DOB (Fecha de Nacimiento): _____

Reason for Visit (Razon de su Visita) :	
Referring Physician (Doctor que lo Refiere) :	Primary Care Physician (Doctor Primario) :
Other Specialists/Surgeons (Otro Especialistas/Cirujanos) :	

HISTORY OF PRESENT ILLNESS

<input type="checkbox"/> High Blood Pressure (Presión Alta) Date of Onset ____/____/____
<input type="checkbox"/> Low Blood Pressure (Presión Baja)

<input type="checkbox"/> Smoker (Fumas)
<input type="checkbox"/> Tobacco Use (Usó de tabaco) _____ Pack(s) per day (Paquetes por día) _____ How many years (Cuantos años)

Are your legs ever bothered by (Ha sentido alguna vez en sus piernas) :

<input type="checkbox"/> Aching/Pain (Ardor/Dolor)
<input type="checkbox"/> Cramping (Calambres) <input type="checkbox"/> Increases with walking (Aumenta al caminar?)
<input type="checkbox"/> Numbness (Entumecimiento)
<input type="checkbox"/> Burning (Quemazón)
<input type="checkbox"/> Restlessness (Inquietud)
<input type="checkbox"/> Tiredness (Cansancio)
<input type="checkbox"/> Wounds (Heridas ó llagas)
<input type="checkbox"/> Throbbing/Tingling (Pulsaciones/Punzadas)
<input type="checkbox"/> Itching (Picazon)
<input type="checkbox"/> Trauma/Surgery of Lower Extremity (Trauma/Cirugía de la extremidad inferior)

<input type="checkbox"/> Discoloration (Decoloración)
<input type="checkbox"/> Swelling/Fullness/Heaviness/Pressure (Hinchazón/Llenura/Pesadez/Presión)
<input type="checkbox"/> Elevation of Legs () <input type="checkbox"/> Exercises for lower extremities ()
<input type="checkbox"/> Take NSAIDS? (Toma anti-inflamatorios?)
<input type="checkbox"/> Prescription Stockings (Medias de compression recetadas)
<input type="checkbox"/> Vein Hemorrhage (Hemorragia en las venas) <input type="checkbox"/> Single/minor (menor) <input type="checkbox"/> Significant major (mayor) <input type="checkbox"/> Transfusion required (Necesitó transfusion?)
<input type="checkbox"/> Other (Otros)

Occupation: (Ocupación)	
Job physical requirements include: (Requisitos físicos de trabajo incluyen:)	
<input type="checkbox"/> Unable to sit (Incapaz de sentarse) <input type="checkbox"/> more than 30 min (Más de 30 min) <input type="checkbox"/> more than 1 hr (Más de 1 hr)	<input type="checkbox"/> Unable to lift (Incapaz de levantar) <input type="checkbox"/> 0-10 pounds (0-10 libras) <input type="checkbox"/> 10-20 pounds (10-20 libras)
<input type="checkbox"/> Unable to walk more than 1 hr (Incapaz de caminar más de 1 hr)	<input type="checkbox"/> Unable to take care of household chores (Incapaz de hacerse cargo de las tareas del hogar)
<input type="checkbox"/> Unable to perform manual task (Incapaz de realizar tarea manual)	
<input type="checkbox"/> Unable to: (Incapaz de:)	<input type="checkbox"/> kneel (arrodillarse) <input type="checkbox"/> squat (agacharse) <input type="checkbox"/> bend (doblarse) <input type="checkbox"/> climb (subir) <input type="checkbox"/> sleep (dormir)
<input type="checkbox"/> Unable to perform daily activities due to: (Incapaz de realizar actividades diarias debido a:) <input type="checkbox"/> leg pain (dolor de pierna) <input type="checkbox"/> swelling (hinchazón)	
Potential limitations with work activity: (Posibles limitaciones con las actividades del trabajo:)	
Limited in ability to do work due to moderate/severe leg symptoms? (Posibles limitaciones con las actividades del trabajo:)	<input type="checkbox"/> Yes (Si) <input type="checkbox"/> No (No)

Name (Paciente): _____ DOB (Fecha de Nacimiento) _____

PAST MEDICAL HISTORY

<input type="checkbox"/> Coronary Artery Disease <i>(Enfermedad de las Arterias Coronarias)</i>	<input type="checkbox"/> Mitral Valve Prolapse <i>(Prolapso de la Valvula Mitral)</i>	<input type="checkbox"/> Diabetes Mellitus <i>(Diabetes)</i> <input type="checkbox"/> IDDM Insulin <i>(Insulina)</i> <input type="checkbox"/> NIDDM Non-Insulin <i>(Sin Insulina)</i>
<input type="checkbox"/> Heart Attack <i>(Infarto)</i>	<input type="checkbox"/> Aneurysm <i>(Aneurisma)</i>	<input type="checkbox"/> COPD- Chronic Obstructive Pulmonary Disease <i>(Efisema o Bronquitis)</i>
<input type="checkbox"/> Congestive Heart Failure <i>(Insuficiencia Cardiaca)</i>	<input type="checkbox"/> Carotid Stenosis <i>(Enfermedad de las Carotidas)</i>	<input type="checkbox"/> Asthma <i>(asma)</i>
<input type="checkbox"/> Stress Test <i>(Prueba de Esfuerzo)</i>	<input type="checkbox"/> TIA-Transischemic Attack (Mini Stoke) <i>(Ataque Isquémico Transitorio)</i>	<input type="checkbox"/> Blood Clot/DVT <i>(Coágulos)</i>
<input type="checkbox"/> Echocardiogram <i>(Ecocardiograma)</i>	<input type="checkbox"/> CVA-Cerebrovascular Accident (Major Stoke) <i>(Derrame Cerebral)</i>	<input type="checkbox"/> Lymphedema Arm/Leg Swelling <i>(Brazo/Piernas Hinchadas)</i>
<input type="checkbox"/> Atrial Fibrillation/Fast Heart Beat <i>(Fibrilacion Auricular/Palpitaciones)</i>	<input type="checkbox"/> Open Wounds <i>(Heridas Abiertas/Ulceras)</i>	<input type="checkbox"/> Anemia- Low Iron Count <i>(Cuenta de Hierro Baja/Anemia)</i>
<input type="checkbox"/> High Cholesterol <i>(El Colesterol alto)</i>	<input type="checkbox"/> Gout <i>(Góta)</i>	
<input type="checkbox"/> Peripheral Vascular Disease <i>(Enfermedad Vasculat Periferica)</i>	<input type="checkbox"/> Arthritis <i>(Artritis)</i>	<input type="checkbox"/> Fibromyalgia <i>(Fibromialgia)</i>
<input type="checkbox"/> Cancer <input type="checkbox"/> Radiation <i>(Cancer) (Radiación)</i> Type <i>(Tipo)</i>	<input type="checkbox"/> Blood Disease/Disorder <i>(Enfermedad de la Sangre)</i> Type <i>(Tipo)</i>	<input type="checkbox"/> # of Pregnancies _____ <i>(Numero de embarazos)</i>

<input type="checkbox"/> CABG Heart Bypass <i>(Bypass o Puentes Coronarios)</i>	<input type="checkbox"/> Pacemaker Defibrillator <i>(Marcapaso o Desfibriladores)</i>
<input type="checkbox"/> Heart Valve Replacement <i>(Reemplazo de Valvula Cardiaca)</i>	<input type="checkbox"/> Heart Cath <i>(Cateterismo Cardiaco)</i>

Name (Paciente): _____

DOB (Fecha de Nacimiento): _____

PAST SURGICAL HISTORY (Cirugias Previas)

Peripheral Vascular Procedures (Procedimientos Vasculares Perifericos)		
<input type="checkbox"/> Bypass Graft or Revision (Puentes Vasculares)	<input type="checkbox"/> Left Leg (Pierna Izquierda)	<input type="checkbox"/> Right Leg (Pierna Derecha)
<input type="checkbox"/> Carotid Artery Surgery (Cirugia de Venas Carotida)	<input type="checkbox"/> Left (Izquierda)	<input type="checkbox"/> Right (Derecha)
<input type="checkbox"/> Aneurysm Repair (Aneurismas)	<input type="checkbox"/> Abdominal Aortic (Aorta Abdominal) <input type="checkbox"/> Popliteal Artery (Arteria Poplitea) <input type="checkbox"/> Open (Abierto) <input type="checkbox"/> Iliac Artery (Arteria Iliaca) <input type="checkbox"/> Endovascular (Tratamiento Endovascular)	
<input type="checkbox"/> Cardio Vascular Procedures (Procedimientos Cardiovasculares) :		

EndoVascular Procedures (Tratamiento Endovascular)		
<input type="checkbox"/> NonCoronary Angiography (Angiograma de las Arterias Perifericas)	<input type="checkbox"/> Left Leg (Pierna Izquierda)	<input type="checkbox"/> Right Leg (Pierna Derecha)
<input type="checkbox"/> Intravascular Stent Placement (Colocacion de Stents)	<input type="checkbox"/> Left Leg (Pierna Izquierda)	<input type="checkbox"/> Right Leg (Pierna Derecha)

Orthopedic (Ortopedico)		
<input type="checkbox"/> Hip Replacement (Reemplazo de Cadera)	<input type="checkbox"/> Left (Izquierda)	<input type="checkbox"/> Right (Derecha)
<input type="checkbox"/> Knee Replacement (Reemplazo de Rodilla)	<input type="checkbox"/> Left (Izquierda)	<input type="checkbox"/> Right (Derecha)
<input type="checkbox"/> Foot Surgeries (Cirugia de los Pies)	<input type="checkbox"/> Left (Izquierda)	<input type="checkbox"/> Right (Derecha)
<input type="checkbox"/> Amputation (Amputacion)	<input type="checkbox"/> Left Leg (Pierna Izquierda) Above (Arriba de) / Below Knee (Debajo de) When (Cuando) : <input type="checkbox"/> Right Leg (Pierna Derecha) Above (Arriba de) / Below Knee (Debajo de) When (Cuando) : <input type="checkbox"/> Other (Otra)	

General Surgery Procedures (Cirugia General)			
<input type="checkbox"/> Hernia Surgery (Cirugia de Hernia)	<input type="checkbox"/> Groin (Inguinal)	<input type="checkbox"/> Left (Izquierdo)	<input type="checkbox"/> Right (Derecha)
<input type="checkbox"/> Skin Debridement (Limpieza de Heridas)			
<input type="checkbox"/> Wound Care (Cuidado de Heridas)	<input type="checkbox"/> Left Leg (Pierna Izquierda)	<input type="checkbox"/> Right Leg (Pierna Derecha)	
<input type="checkbox"/> Gastric Surgery (Cirugia Garstrica)	<input type="checkbox"/> Bypass (Bypass)	<input type="checkbox"/> Banding (Banda o anillo)	
<input type="checkbox"/> Other Surgeries/Procedures (Otras Cirugias)			

Vein Procedures (Procedimientos de las Venas)		
<input type="checkbox"/> Inferior Vena Cava Filter/IVC Filter (Filtro de la Vena Cava Inferior)		
<input type="checkbox"/> Varicose Vein Surgery (Cirugia de Venas Varicosa)	<input type="checkbox"/> Left Leg (Pierna Izquierda) When (Cuando) : <input type="checkbox"/> Right Leg (Pierna Derecha) When (Cuando) :	
<input type="checkbox"/> Sclerotherapy Injections (Inyecciones de Escleroterapia)	<input type="checkbox"/> Left Leg (Pierna Izquierda) # of Treatments (# de Tratamientos) _____ <input type="checkbox"/> Right Leg (Pierna Derecha) # of Treatments (# de Tratamientos) _____	

Name (Paciente): _____

DOB (Fecha de Nacimiento): _____

Review of Symptoms *(Revisar de Sintomas)*

- Recent Illness *(Enfermedades Recientes)*
- Fever *(Fiebre)*
- Recent Weight Change *(Cambio de Peso Reciente)*
- Headaches *(Dolores de Cabeza)*
- Feeling Fine *(Se Siente Bien)*
- Eye/Vision Problems *(Problemas de Visión)*
- Wears Glasses *(Usa Lentes/Espejuelos)*
- Blindness *(Ceguera)*
 Left Eye *(Ojo Izquierdo)* Right Eye *(Ojo Derecho)*
- Temporary Vision Loss *(Perdida Transitoria de la Visión)*
 Left Eye *(Ojo Izquierdo)* Right Eye *(Ojo Derecho)*
- Hearing Loss *(Perdida de Audición)*
 Left Ear *(Oído Izquierdo)* Right Ear *(Oído Derecho)*
- Difficulty Swallowing *(Dificultad al Tragar)*
- Neck Pain *(Dolor de Cuello)*
- Jaw Pain During Exercise
(Dolor de la Quijada Durante Ejercicios)
- Chest Pain or Discomfort
(Dolor o molestia en el Pecho)
- Anxiety *(Ansiedad)*
- Depression *(Depresión)*
- Bleed Easily *(Sangra Fácilmente)*
- Bruise Easily *(Hace Hematomas Fácilmente)*

- Soft Tissue Swelling
- Blood Thinners *(Coagulantes)*
- Abdominal Pain *(Dolor abdominal)*
- Nausea *(Náusea)*
- Vomiting *(Vómitos)*
- Shortness of Breath *(Falta de aliento)*
- Dizziness *(Mareos)*
- Lightheadedness *(Sensación de Desvanecimiento)*
- Fainting *(Desmayos)*
- Convulsions/Seizure Disorder
(Convulsiones/Epilepsia)
- Palpitations/Fast Heart Rate *(Palpitaciones)*
- Slow Heart Rate *(Latidos lentos del Corazon)*
- Cold Hands/Feet *(Manos Frias/Pies Frios)*
- Skin Wound or Ulcer *(Ulceras/heridas en la piel)*
- Leg Symptoms *(Dolor en las Piernas)*
- Leg Pain with Exercise
(Dolor de Pierna Durante el Ejercicio)
- Back Symptoms *(Molestias en la Espalda)*
- Hip Symptoms *(Molestias en las Caderas)*
- Chronic Cough *(Tos Cronica)*
- Dry Skin *(Piel Seca)*
- Cracking of Skin *(Piel Cuarteada)*

FAMILY HISTORY *(Historia Familiar)*

<input type="checkbox"/> Cancer <i>(Cancer)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Heart Disease <i>(Enfermedades Cardiacas)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> High Blood Pressure <i>(Presión Alta)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Early Deaths <i>(Muertes a temprana edad)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Diabetes <i>(Diabetis)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Aneurysm <i>(Aneurisma)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Blood Clots <i>(Coágulos en la Sangre)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> CVA - Cerebrovascular Accident/Major Stroke <i>(Accidente-Cerebrovascular/Derrame)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> TIA – Trans Ischemic Attack/Mini Strokes <i>(Ataque Isquémico)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>
<input type="checkbox"/> Varicose Veins <i>(Venas Varicosas)</i>	<input type="checkbox"/> Mother <i>(Madre)</i> <input type="checkbox"/> Father <i>(Padre)</i> <input type="checkbox"/> Sister <i>(Hermana)</i> <input type="checkbox"/> Brother <i>(Hermano)</i> <input type="checkbox"/> Grandparent Maternal/Paternal <i>(Abuelos Maternos/Paternos)</i>

Name (Paciente): _____

DOB (Fecha de Nacimiento): _____

SOCIAL HISTORY (Historia Social)

<input type="checkbox"/> Alcohol Use (Uso de Alcohol)	_____ Drink(s) per day (Bebidas por día) _____ Drink(s) per week (Bebidas a la semana)
<input type="checkbox"/> Drug Use (Uso de Drogas)	Type (Tipo): _____
<input type="checkbox"/> Physical Disabilities (Desabilidad Fisica)	<input type="checkbox"/> Unable to Stand (Incapaz de pararse) <input type="checkbox"/> Do Not Walk (No puedes andar) <input type="checkbox"/> Unable to Walk more than _____ feet (No puedes andar mas de _____ pies) <input type="checkbox"/> Severe breathing problems (Problemas Respiratorios Severos) <input type="checkbox"/> Oxygen Dependant (Dependiente de oxígeno)
<input type="checkbox"/> Exercise Habits (Ejercicios)	<input type="checkbox"/> Walk (Andar) <input type="checkbox"/> Work out (Ejercicio) <input type="checkbox"/> Daily (Diario) <input type="checkbox"/> Weekly (Semanal) <input type="checkbox"/> Biweekly (Quincenal) <input type="checkbox"/> Other (Otro) _____
<input type="checkbox"/> Difficulty Understanding English (Dificultad Entendiendo Ingles)	Native Language (Lenguaje de Nacionalidad): _____
<input type="checkbox"/> Homebound (Restringida o en la Casa)	I am homebound and unable to leave home unassisted. (Estoy restringido y no puedo salir de mi casa.)
<input type="checkbox"/> Significant Other (Tienes Pareja)	I am living with a significant other. (Yo estoy viviendo con mi pareja.)
<input type="checkbox"/> Assisted Living Facility (Facilidad de vivienda asistide)	I am living in an Assisted Living Facility. (Yo estoy viviendo en una facilidad de vivienda asistida.)
<input type="checkbox"/> Skilled Nursing Facility (Ancianato)	I am living in a Skilled Nursing Facility. (Yo estoy viviendo en un Ancianato/Asilo de Ancianos)
<input type="checkbox"/> Home Environment (Ambiente del hogar)	I am living in a secure/supportive home environment. (Yo estoy viviendo en un hogar con ambiente seguro.)
<input type="checkbox"/> Caregiver (Cuidador)	I have a caregiver. (Yo tengo una persona que me cuida.)
<input type="checkbox"/> Powers of Attorney (Poder de Potestad)	I have assigned powers of attorney to (Yo he firmado un poder de potestad.)

Name (Paciente): _____

DOB (Fecha de Nacimiento): _____

MEDICATIONS (Medicamentos)

		Frequency (Frecuencia)			
Medication Name (Medicamentos)	Strength (Milligramos)	Once Daily (Una Diario)	Two times Daily (Dos veces al día)	Every ___ hours (Cada ___ Horas)	Other (Otra)
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	
		<input type="checkbox"/>	<input type="checkbox"/>	____ hours/horas	

ALLERGIES (Alergias)

No Known Allergies (Alergias Conocidas)
 Are you allergic to latex or to iodine?

Allergy (Alergias)	Type of Reaction (Tipo de Reaccion)				
	Rash (Alergia en la Piel)	Nausea Vomiting (Nausea Vomitos)	Difficulty Breathing (Dificultad para respirar)	Coma (Coma)	Other (Otra)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	