



Buffalo
Vascular Care

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Buffalo Vascular Care (Main Office)
6337 Transit Road
Lancaster, NY 14086

United Memorial Medical Center
229 Summit Street, Suite 8
Batavia, NY 14020

New Patient Package

Appointment: 00/00/0000 --:--

Welcome to our practice.

To ensure the highest level of consultation and care by our professional staff, it is important that you provide us with the following information:

1. Please complete the enclosed forms and bring them to your scheduled appointment or **you can complete the information on our patient portal, portal activation is an insurance requirement** (your activation instructions are enclosed)
2. Obtain any necessary referrals.
3. Obtain any reports and films/CDs of diagnostic tests which were performed for this problem(s).
4. Co pay is required at time services are rendered.

IT IS YOUR RESPONSIBILITY: to ensure that your medical records get to our office prior to your appointment, have this information faxed to us or please bring the information in the day of your appointment. Failure to receive the information may result in postponement of your consultation.

Directions:

- **MAIN OFFICE**** Buffalo Vascular Care: 6337 Transit Road Lancaster, NY 14043
- Batavia: 229 Summit Rd. Suite 8 Batavia, NY 14020

Thank you and we look forward to participating in your health.



Name:

Date:

Past Medical History

- Endocrine: Diabetes Thyroid Disease
- Cardiac: High Cholesterol High Blood Pressure Coronary Disease
- MI/heart attacks Congestive Heart Failure Atrial Fibrillation
- Angina Valve Disorder Bleeding problems
- Hematologic: Anemia DVT (leg clots) Pulmonary Emboli (lung clots)
- Skin: Chronic Wounds Varicose veins
- Gastrointestinal: Heart Burn, Reflux Stomach Ulcers
- Respiratory: COPD/Emphysema Asthma
- Psychiatric: Depression Bipolar Disorder Anxiety
- Neurological: Stroke Headaches Seizures
- Musculoskeletal: Arthritis Osteoporosis Back pain
- Kidney: Renal insufficiency Kidney failure on dialysis
- Cancer (type) _____ Other: _____

Past Surgical History

- None Cataracts Tonsillectomy Adenoidectomy Thyroidectomy
- Coronary Bypass Cardiac Stents Pacemaker Heart Valve Gall Bladder
- Appendectomy Bowel/Stomach Bariatric surgery C-Section Hysterectomy
- Hernia Spinal Surgery Tubal Ligation Bladder surgery Prostate
- Leg artery stent Leg bypass Orthopedic/joints _____
- Other: _____

Family History

- Diabetes High Blood Pressure Heart Disease Blood Clots Varicose Veins Stroke High Cholesterol
- Cancer: _____ Other: _____

Social History

- Marital status: Never married Married Divorced Widowed
- Tobacco use: Never smoked Chews Tobacco
- Current smoker Packs per day: _____ Number of years smoking: _____
- Former smoker Year when quit: _____
- Alcohol use: Never Occasionally Daily Rarely Former
- Employment: Employed Full time/Part time Unemployed Disabled Retired

Completion of this information is required by your insurance:

Have you completed a Health Care Proxy Form? No Yes Declined (See attached form)



Name:

Date:

Constitutional Symptoms

Good general health lately Yes/No
Recent weight change Yes/No
Fever Yes/No
Fatigue Yes/No

Genitourinary

Frequent urination Yes/No
Burning or painful urination Yes/No
Female - date of last pap smear _____
Female - # of pregnancies _____

Psychiatric

Memory loss or confusion Yes/No
Nervousness Yes/No
Depression Yes/No
Insomnia Yes/No

Eyes/Ears/Nose/Mouth/Throat

Eye disease or injury Yes/No
Hearing loss or ringing Yes/No
Earaches or drainage Yes/No
Nose bleeds Yes/No
Mouth sores Yes/No
Bleeding gums Yes/No
Chronic sinus problems or rhinitis Yes/No
Sore throat or voice change Yes/No
Swollen glands in neck Yes/No

Endocrine

Glandular/hormone problems Yes/No
Excessive thirst or urination Yes/No
Heat Intolerance Yes/No

Hematologic/Lymphatic

Bleeding problems Yes/No
Anemia Yes/No
Slow to heal after cuts Yes/No
Phlebitis Yes/No
Past transfusion Yes/No
Enlarged glands Yes/No

Musculoskeletal

Joint stiffness or swelling Yes/No
Weakness of muscles or joints Yes/No
Muscle pain or cramps Yes/No
Back pain Yes/No
Joint pain Yes/No
Cold Extremities Yes/No
Difficulty in walking Yes/No

Allergic/Immunologic

Iodine Yes/No
Contrast Dye Yes/No
Novocain or other anesthetics Yes/No
Penicillin or other antibiotics Yes/No

Cardiovascular

Heart trouble Yes/No
Chest pains or angina pectoris Yes/No
Palpitation Yes/No
Shortness of breath w/ walking or lying flat Yes/No
Swelling of feet, ankles or hands Yes/No

Integumentary (skin, breast)

Rash or itching Yes/No
Change in skin color Yes/No
Change in hair or nails Yes/No
Varicose veins Yes/No

Neurological

Frequent or recurring headaches Yes/No
Light headed or dizzy Yes/No
Convulsions or seizures Yes/No
Head injury Yes/No
Tremors Yes/No
Paralysis Yes/No
Numbness or tingling sensations Yes/No

Respiratory

Chronic or frequent coughs Yes/No
Spitting up blood Yes/No
Shortness of breath Yes/No
Wheezing Yes/No

Gastrointestinal

Loss of appetite Yes/No
Frequent diarrhea Yes/No
Constipation Yes/No
Abdominal Pain Yes/No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian _____

Today's Date: _____

Visit our website www.viabuf.com for additional information and educational resources.



Health Care Proxy

I, _____, Date: _____, hereby appoint

(Name of person you elect to be your health care proxy, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

(Appointee's name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

Your Name: _____

Your Signature _____ **Date** _____

Your Address: 6337 Transit Road, Depew NY 14043

Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

- Any needed organs and/or tissues
- The following organs and/or tissues _____
- Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Name: _____

Your Signature _____ Date _____

Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____
Name of Witness 1 _____ Name of Witness 2 _____
Signature _____ Signature _____

