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p: 716.852.1977
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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:

Date of Birth:
Preferred Language: ☐English ☐Spanish ☐Other___________
Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino
Race: ☐White ☐African American ☐Asian ☐American Indian ☐Other_______ ☐Declined
Gender: ☐Male ☐Female

Address:____

Home Phone #: _______________Cell Phone #:________________Work Phone #: _______________

Emergency Contact Name:_______________________Phone#: _____________________

Primary Care Provider: ________________________ Referring Provider: ______________________________

Cardiologist: _________________________________Podiatrist: _____________________________________

Nephrologist: ________________________________Other physicians: _______________________________

Reason for visit:

____

____

Medication List *Please provide a complete list of all medications that you are currently taking.*

Prescription Medication	**Dose**	**Frequency**

Medication Allergies	**Reaction Description**

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

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

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

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

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

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

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

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

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

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

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 ___________________________________

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Lower Extremity Vascular Disease Questionnaire

****ONLY TO BE COMPLETED IF BEING CONSULTED FOR LEG PAIN/ ULCERS****

Name: ____ Date: ____________

Who referred you to our practice or how did you hear about our practice? ______________________

Please complete history:

☐ Yes ☐ No Currently smoke? If no: When did you quit? _____ Packs / day? _____ # of years smoking?_____
☐ Yes ☐ No Diabetes. How many years have you had diabetes? __________
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No High cholesterol
☐ Yes ☐ No Heart attack
☐ Yes ☐ No Heart bypass or coronary stents
☐ Yes ☐ No Stroke
☐ Yes ☐ No TIA (mini stroke)
☐ Yes ☐ No Carotid artery disease
☐ Yes ☐ No Carotid artery endarterectomy or stenting
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No CHF
☐ Yes ☐ No COPD
☐ Yes ☐ No Asthma
☐ Yes ☐ No Bleeding problems
☐ Yes ☐ No History of previous surgeries and/or angioplasty or stent on the arteries in legs
☐ Yes ☐ No History of vein stripping in your legs
☐ Yes ☐ No Clots in your legs or lungs
☐ Yes ☐ No Family member who has varicose veins. Please list ______________________________
☐ Yes ☐ No Take blood thinners. Name of medication ______________________________
☐ Yes ☐ No Contrast dye allergy. Reaction ______________________________
☐ Yes ☐ No Pneumonia vaccination. Date received: ____________ Check here ☐ if declined to receive
☐ Yes ☐ No Flu vaccination. Date received: ____________ Check here ☐ if declined to receive
☐ Yes ☐ No Do you have open sores or ulcers on your leg(s) or feet that will not heal?

If you answered "yes":

Where are the ulcers located?______________________________

How long have the ulcers been present? ______________________________

☐ Yes ☐ No Do you have leg pain / discomfort?

If you answered "yes":

How many weeks / months / years have you had pain/discomfort? ______________________

The pain/discomfort is in the ☐ right leg ☐ left leg ☐ both legs

The pain/discomfort is described as: ☐ aching ☐ cramping ☐ heavy feeling ☐ swelling ☐ restless feeling ☐ itching ☐ other:______________________

☐ Yes ☐ No Is the pain worse at night?
☐ Yes ☐ No Is the pain worse with walking? How far can you walk: ____________________

☐ Yes ☐ No Does elevating your leg help?

☐ Yes ☐ No Does dangling your leg over the side of the bed help?

☐ Yes ☐ No Do you use compression stockings? Duration of use: ____

☐ Yes ☐ No Do you have varicose veins: right leg left leg both legs labia/scrotum

☐ Yes ☐ No Do you have leg discoloration or texture changes right leg left leg both legs Yes

☐ Yes ☐ No Do you have pelvic pain or pressure?

☐ Yes ☐ No Do your symptoms affect quality of your life? Describe: ____

☐ Yes ☐ No Did you have ultrasound, CTA or MRA of your legs or abdomen?

Date: ____________ Facility: ____________________

You must bring CD of your MRA or CTA to your appointment so we may view your images.

Report of the study that is sent to us from your referring physician is not enough.