Vascular Interventional Associates at
Buffalo Vascular Care

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Buffalo Vascular Care (Main Office)
6337 Transit Road, Depew, NY 14043
Satellite Office
190 Washington Avenue, Batavia, NY 14020

Welcome to our practice!

We are looking forward to seeing you. Here is important information prior to your appointment:

1. **Please complete the enclosed forms and bring them to your scheduled appointment**
2. Drop off CDs of diagnostic tests (CT, CTA, MR or MRA) which were performed for this problem **1 week prior to appointment**.
3. Copay is required at time of your visit.
4. If ultrasound testing is required after your consult, please plan for an additional 1.5-2 hours for your appointment.
5. Please DO NOT apply perfumes, colognes or heavily scented lotions prior to coming to our office.
6. Masks must be worn when you enter our facility and must remain on during the entire time, covering BOTH your mouth and nose. You will be asked a COVID screening questionnaire when you enter the building. If you or your family member have symptoms of COVID-19 or have been exposed, please call to reschedule your visit to telehealth or another date.
7. Please bring a copy of your COVID vaccination card to your appointment.

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

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

Name: Date of Birth:

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

Reason for visit:

_____

Medications (complete list required) **Dose** **Frequency**

You can ask your pharmacist to print your medication list and bring it with you instead of filling out this part

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies **Reaction Description**

_____
_____
_____

Past Medical History - **do you have any of the following conditions?**

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): left / right	☐Pulmonary Emboli (lung clots)
Skin:	☐Chronic Wounds	☐Varicose veins	
Gastrointestinal:	☐Heart Burn, Reflux	☐Stomach Ulcers	
Respiratory:	☐COPD/Emphysema	☐Sleep apnea	☐Asthma
Psychiatric:	☐Depression	☐Bipolar Disorder	☐Anxiety
Neurological:	☐Stroke	☐Headaches	☐Seizures
Musculoskeletal:	☐Arthritis	☐Osteoporosis	☐Back pain
Kidney:	☐Renal insufficiency	☐Kidney failure on dialysis	Nephrologist:_____
☐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	☐Carotid artery stent	☐Orthopedic/joints_____	
☐Other_____				

Family History - **do/did your parents and siblings have/had any of the following conditions?**

☐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

Name: 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

Flu vaccination: Date received_____ Declined to receive: ☐
Pneumonia vaccination if >65 years old: Date received_____ Declined to receive: ☐
COVID vaccination Date of 1st dose received: _____ Date of 2nd dose receieved: _____ Declined to receive: ☐
☐ Moderna ☐ Pfizer ☐Johnson & Johnson

Check all that pertain to you:

Constitutional Symptoms
☐Good general health lately
☐Recent weight: gain / loss
☐Fever
☐Fatigue

Eyes/Ears/Nose/Mouth/Throat
☐Eye disease or injury
☐Hearing loss or ringing
☐Earaches or drainage
☐Nose bleeds
☐Mouth sores
☐Bleeding gums
☐Chronic sinus problems or rhinitis
☐Sore throat or voice change
☐Swollen glands in neck

Cardiovascular
☐Heart trouble
☐Chest pains or angina pectoris
☐Palpitation
☐Shortness of breath w/ walking or lying flat
☐Swelling of feet, ankles or hands

Respiratory
☐Chronic or frequent coughs
☐Spitting up blood
☐Shortness of breath
☐Wheezing

Genitourinary
☐Frequent urination
☐Burning or painful urination
☐Female - date of last pap smear ____
☐Female - # of pregnancies ____

Endocrine
☐Glandular/hormone problems
☐Excessive thirst or urination
☐Heat Intolerance

Musculoskeletal
☐Joint stiffness or swelling
☐Weakness of muscles or joints
☐Muscle pain or cramps
☐Back pain
☐Joint pain
☐Cold Extremities
☐Difficulty in walking

Integumentary (skin, breast)
☐Rash or itching
☐Change in skin color
☐Change in hair or nails
☐Varicose veins

Gastrointestinal
☐Loss of appetite
☐Frequent diarrhea
☐Constipation
☐Abdominal Pain

Psychiatric
☐Memory loss or confusion
☐Nervousness
☐Depression
☐Insomnia

Hematologic/Lymphatic
☐Enlarged glands
☐Anemia
☐Slow to heal after cuts
☐Phlebitis
☐Past transfusion

Allergic/Immunologic
☐Iodine
☐Contrast Dye
☐Novocain or other anesthetics
☐Penicillin or other antibiotics

Neurological
☐Frequent or recurring headaches
☐Light headed or dizzy
☐Convulsions or seizures
☐Head injury
☐Tremors
☐Paralysis

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:_____

Provider Signature:_____ Date:_____

Health Care Proxy

I, _____, Date of birth: _____, 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:

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.

Test Test , 01/01/2001
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 _____