WISHON INTERVENTIONAL SPECIALISTS

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Visit us at **wishonIR.com** for more details on our doctors, procedures and locations.

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New Patient History Form

Please complete & bring to appointment with a photo id & insurance card.

Appointment Date/Time

Name (Last, first, middle initial) | Date of Birth | Age

Address, City, ST, ZIP Code | Social Security #

Home phone number | Cell phone number | Email address

Emergency Contact/Caregiver phone number | Relationship

Allergies:

Symptoms/Complaints:

Please describe your symptoms and complaints:

Past Medical History

Please indicate any past diagnosed illnesses:

Past Surgery History

Please indicate any past surgeries:

Family History

Please indicate any conditions that run in your family:

Social History

Smoke: YES / NO Packs per day? _____ Years? _____ If quit, what year? _____

Drink Alcohol: YES / NO How often? _____

List of Medications. Please list below or attach a written list.

Name of Medication	Strength	What is the medication for?

Relevant Imaging History

List relevant Ultrasound/MRI/CT/X-rays procedures done	Where?	When? (month/year)

Review of Systems Update: Please check the box if you have any UPDATED problems listed below:

General

- ☐ Fever or chills
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Congestive heart failure
- ☐ Stroke
- ☐ Leg swelling

SHEENT:

- ☐ Easy bruising
- ☐ Rash
- ☐ Sores/ulcers
- ☐ Hair loss
- ☐ Itching
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Sinus congestion
- ☐ Frequent nose bleeds
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Glasses or contact lenses
- ☐ Blurred or double vison
- ☐ Visual loss
- ☐ Pain or redness in eye

Neurological

- ☐ Frequent headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Seizure
- ☐ Head injury
- ☐ Stroke
- ☐ Memory Loss
- ☐ Dizziness

Respiratory:

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Emphysema
- ☐ Asthma
- ☐ Tuberculosis

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Drug or alcohol abuse

Gastrointestinal:

- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in BMs
- ☐ Bloody/black stool
- ☐ Vomiting blood
- ☐ Jaundice
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Ulcers

Genitourinary:

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Kidney disease/failure

Hematologic/Lymph:

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Anemia
- ☐ Enlarged glands
- ☐ AIDS or HIV positive

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling/stiffness
- ☐ Joint replacement
- ☐ Back pain
- ☐ Leg pain with walking
- ☐ Muscle weakness

Endocrine

- ☐ Diabetes
- ☐ Thyroid problems/goiter
- ☐ Heat/cold intolerance

Allergic/Immunologic

- ☐ Allergy to antibiotic
- ☐ Allergy to iodine or IVP dye
- ☐ Allergy to local anesthetic
- Reaction to general anesthesia
- ☐ Food allergies

Imaging/Procedure Screening

- ☐ Claustrophic
- ☐ Stents, filters, coils
- ☐ Metal in eyes/body
- ☐ Metal rods/joint replacement
- ☐ Renal/Blood disease
- ☐ On blood thinners
- ☐ Pregnant/Nursing
- ☐ Other

Other_____

Patient Signature _____ **Date** _____

_____

Printed Name