

ATTENDING: \_\_\_\_\_  
 REFERRED BY: \_\_\_\_\_  
 OFFICE TEL#: \_\_\_\_\_  
 CC: \_\_\_\_\_  
 HPI: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DX:** Male Female **Age:** \_\_\_\_\_ **Race:** Caucasian Black Hispanic Asian Native American Other

**ALLERGIES / REACTIONS:** \_\_\_\_\_  
 Contrast Allergy Yes No

**PHM:** (Circle Positives) COPD ASTHMA HTN ESRD STROKE MI CAD DM GI BLEED HEPATITIS PUD CANCER

**FH:** \_\_\_\_\_ **SH:** \_\_\_\_\_

| MEDS | DOSE | FREQ. | MEDS | DOSE | FREQ. |
|------|------|-------|------|------|-------|
|      |      |       |      |      |       |
|      |      |       |      |      |       |
|      |      |       |      |      |       |
|      |      |       |      |      |       |

**REVIEW OF SYSTEMS**

**CONSTITUTIONAL** Fever Fatigue Wt Loss Wt Gain \_\_\_\_\_  
**SKIN** Rash Pruritus Ulcers \_\_\_\_\_  
**HEENT** Headache Vision Change Adenopathy Hearing Loss Glasses/Contacts \_\_\_\_\_  
**RESPIRATORY** Cough Sputum SOB Wheeze Pneumonia Sleep Apnea \_\_\_\_\_  
**CARDIOVASCULAR** Chest Pain Murmur Palpitation Arrhythmias PVD Edema Claudication Syncope \_\_\_\_\_  
**GI** Dysphagia Abd Pain Reflux N/V Diarrhea Constipation Hematemesis Hematochezia \_\_\_\_\_  
**GU** Frequency Hematuria Oliguria Dyspareunia Vaginal Bleeding Pelvic Pain \_\_\_\_\_  
**ENDOCRINE** Hot/Cold flash Thyroid Disease \_\_\_\_\_  
**NEURO** Paresthesias Seizures \_\_\_\_\_  
**HEMATOLOGY** Anemia Coagulopathy \_\_\_\_\_  
**PSYCH** Depression Anxiety Dementia \_\_\_\_\_  
**MUSCULOSKELETAL** Joint Pain (Gout, DJD, RA) \_\_\_\_\_

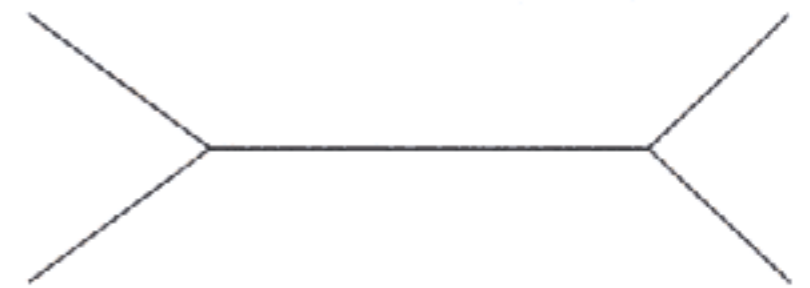
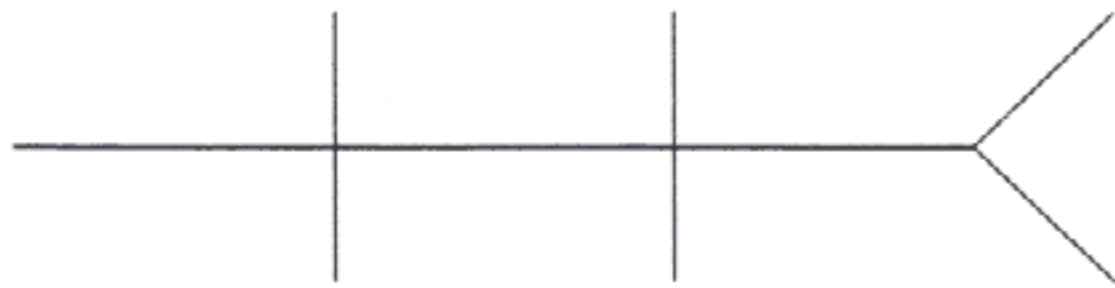
Signature of MD / NP / FELLOW / RESIDENT: \_\_\_\_\_  
 Date & Time: \_\_\_\_\_

Patient Label

**INTERVENTIONAL RADIOLOGY  
 HISTORY & PHYSICAL**

Conscious Sedation Airway Assessment    \*\*Yes answers may require Anesthesia Consult

| Pre-Procedure Assessment Date   | Yes** | No |
|---|-------|----|
| History of Previous Anesthetic problem / Complications including family history |       |    |
| History of airway problems / Difficult intubation                               |       |    |
| Airway examination:   |       |    |
| Tracheal deviation  |       |    |
| Short thick neck or invisible neck  |       |    |
| Visible anterior neck masses  |       |    |
| Small mouth opening (less than 3 finger breaths)                                |       |    |
| Oxygen Saturation < 92% on room air   |       |    |



PT \_\_\_\_\_ INR \_\_\_\_\_

Additional Test Results \_\_\_\_\_

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Signature of MD / NP / FELLOW / RESIDENT: \_\_\_\_\_

Date & Time: \_\_\_\_\_

Patient Label

**INTERVENTIONAL RADIOLOGY  
HISTORY & PHYSICAL**

# PHYSICAL EXAM

VS: T \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ BP \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

GENERAL / PSYCH:  Cooperative, alert and oriented \_\_\_\_\_

SKIN:  No rashes  No Ulcerations \_\_\_\_\_

LYMPHATIC:  No Adenopathy \_\_\_\_\_

HEENT:  PERRLA  Trachea Midline  Dentures  
 No JVD \_\_\_\_\_

RESPIRATORY:  CTA  NL Percussion \_\_\_\_\_

CV:  RRR  S1  S2  No Murmur/Rubs/Gallops  Edema \_\_\_\_\_

**PERIPHERAL PULSES:**

0 = Absent  
 2 = WNL  
 B = Bruits  
 NB = No Bruits  
 D = Doppler Only

|   |          |        |      |      |      |
|---|----------|--------|------|------|------|
| R |          |        |      |      |      |
| L |          |        |      |      |      |
|   | Carotids | Radial | Fem. | P.T. | D.P. |

GI:  +BS  Soft/Nontender No Masses  No Organomegaly \_\_\_\_\_

MUSCULOSKELETAL:  NL Strength/Tone  NL Symmetry \_\_\_\_\_

NEURO:  NL Cranial Nerves  NL Sensation  NL Gait \_\_\_\_\_

GYN: \_\_\_\_\_

ADDITIONAL FINDINGS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

STUDIES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

|           |            |      |
|-----------|------------|------|
| ABI INDEX | PRE        | POST |
| R         |            |      |
| L         |            |      |
|           | (exercise) |      |

IMPRESSION / PLAN: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I agree with the history and physical above. In addition, I have performed a supplementary exam, making changes to the history or exam as noted.

NP / FELLOW / RESIDENT SIGNATURE: \_\_\_\_\_

ATTENDING SIGNATURE: \_\_\_\_\_

DATE & TIME: \_\_\_\_\_

DATE & TIME: \_\_\_\_\_

Patient Label