Precision Vascular & Interventional

Name_____

General Patient Questions **Age**_____

Reason for Visit_____

General History		
Anemia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Blood transfusion	Yes	No
Cancer	Yes	No
Breast	Yes	No
Colon	Yes	No
Lung	Yes	No
Prostate	Yes	No
COPD / Emphysema	Yes	No
Diabetes	Yes	No
Dialysis	Yes	No
GERD / Ulcers	Yes	No
Glaucoma	Yes	No
Heart attack	Yes	No

Heart failure	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
High blood pressure	Yes	No
High thyroid	Yes	No
HIV / AIDS	Yes	No
Keloid formation	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Low thyroid	Yes	No
Lupus	Yes	No
Migraines	Yes	No
Pneumonia	Yes	No
Seizure	Yes	No
Stroke	Yes	No

Comments

Leg Pain History		
Aching	L	R
Swelling	L	R
Cramping	L	R
Tired	L	R
Heavy	L	R
Itching	L	R
Spider veins	L	R
Purple / Blue veins	L	R
Abdominal veins	L	R
Bulging veins	L	R
Deep vein thrombosis	L	R
Blood clots to lungs	L	R
Skin discolored	L	R

Cold feet	L	R
Foot pain	L	R
Nail loss	L	R
Restless legs	L	R
Hair loss on leg	L	R
Calf cramps walking	L	R
Foot pain wakes you	L	R
Dangle leg for relief	L	R
Foot sore not healing	L	R
Purple spots on feet	L	R
Leg ulcer	L	R
Erectile dysfunction	Yes	No
Bleeding tendency	Yes	No

Attempted Treatments		
Leg elevation	Yes	No
Walking	Yes	No
Exercise	Yes	No
Warm Soaks	Yes	No
Cold packs	Yes	No
Support hose	Yes	No
Wraps	Yes	No
Pain meds	Yes	No
Ibuprofen	Yes	No
Tylenol	Yes	No
Aspirin	Yes	No

Vascular Family History	Mother		Father		Sibling	
Spider veins	Yes	No	Yes	No	Yes	No
Varicose veins	Yes	No	Yes	No	Yes	No
Deep vein thrombosis	Yes	No	Yes	No	Yes	No
Clotting disorder	Yes	No	Yes	No	Yes	No
Skin ulcer on leg	Yes	No	Yes	No	Yes	No

Prior Vascular Procedures	Year

Precision Vascular & Interventional

Name_____

Activity Level	
Fully active	0
Restricted in strenuous activity, able to do light work	1
Can walk, provide all self care, moves more than 50% while awake	2
Limited self care, confined to bed more than 50% while awake	3
Disabled, no self care, completely confined to bed or chair	4

Social History			Type / Frequency / How long
Alcohol use	Yes	No	
Tobacco use	Yes	No	
Recreational drug use	Yes	No	

Previous Hospitalizations	Year

Previous Surgery	Year

Active Medical Problems	Onset

Allergies	Reaction

Family History	Alive		Medical Problems
Mother	Yes	No	
Father	Yes	No	
Brother	Yes	No	
Sister	Yes	No	
	Yes	No	
	Yes	No	

Precision Vascular & Interventional

Name_____

Medications	Reason for Med.

Review of Systems	**Circle all that apply**	
Constitutional Symptoms	**Eyes**	**Gastrointestinal**
Good general health	Wear glasses	Heartburn
Recent weight loss	Wear contact lenses	Loss of appetite
Recent weight gain	Blurred or double vision	Nausea or vomiting
Fever	Cataracts	Diarrhea
Chills	**Ears / Nose / Mouth / Throat**	Constipation
Fatigue	Hearing loss	Blood in bowel movements
Night Sweats	Ringing in the ears	Abdominal pain
Cardiovascular	Earaches	**Neurological**
Heart trouble	Sinus problem	Frequent or recurring headaches
Palpitations	Nose bleeds	Light headed or dizzy
Chest pain or angina pectoris	Mouth sores	Tremors
Shortness of breath with walking	Voice change	Paralysis
Shortness of breath lying flat	Sore throat	**Allergic/Immunologic**
Swelling of feet or ankles	Swollen glands in neck	Prior adverse reaction to:
Respiratory	**Musculoskeletal**	Penicillin or other antibiotics
Chronic cough	Back pain	Morphine or other narcotics
Shortness of breath	Pain radiating down legs	Lidocaine or other anesthetics
Wheezing	Hip pain	Aspirin or other pain remedies
Coughing up blood	Knee pain	Iodine
Genitourinary	Shoulder pain	Betadine
Burning or painful urination	Joint swelling	**Skin / Breast**
Blood in urine	Muscle weakness	Rash
Change in force of stream	Muscle cramps	Breast discharge
Incontinence or dribbling	Difficulty walking	Breast lump
Kidney stones	**Hematologic/Lymphatic**	**Psychiatric**
Endocrine	Slow to heal after cuts	Memory loss
Glandular or hormone problem	Bleeding or bruising tendency	Nervousness
Excessive thirst or urination	Past transfusion	Depression
Heat or cold intolerance	Enlarged glands	Confusion
		Insomnia