Patient History:

TODAY'S DATE: _____

PATIENT'S NAME: _____ DOB: ____ AGE: _____

Referring Physician: _____

Primary Care Physician (family doctor): _____

Physicians you wish to receive reports: _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY:

Do you have or have you ever had known vascular disease? If yes, what type?

Arterial _____ Venous ____

__Emphysema/COPD

__Asthma

__ Sleep Apnea _ CPAP

__Heart Attack

__Congestive Heart Failure

__Artificial Heart Valve

__Coronary Artery Disease

__Atrial Fibrillation

__Arrhythmia (Irregular heartbeat)

__Pacemaker/Defibrillator

__Arthritis

__Hypertension (High Blood Pressure)

__ (High Cholesterol)

__Depression/Anxiety

__Diabetes __Type 1__2

__Thyroid disorder

__Stroke/ TIA__

__DVT/PE__/Filter

__Carotid stenosis

__Aneurysm

__GERD

__IBS/Crohn's

__Bleeding disorder

__Kidney disease__Dialysis___

__HIV/AIDS

__Seizure disorder

__Multiple Sclerosis

__Psychiatric disorder

PATIENT'S NAME: _____ DOB: ____ AGE: ____

Surgical History:

Yes/No Vein ligation/stripping
Yes/No Vein ablation
Yes/No Vascular Surgical Intervention_R_L (Arterial bypass/Stenting)
Yes/No Appendectomy
Yes/No Mastectomy_ R _ L
Yes/No Cholecystectomy (Gallbladder) ____
Yes/No Colon/Rectal Surgery
Yes/No C-Section
Yes/No Gastric Bypass/Sleeve
Yes/No Heart Bypass (CABG)
Yes/No Heart Stents
Yes/No Heart Valve Replacement ____
Yes/No Hysterectomy
Yes/No Joint Replacement
Which Body Part?_____
Yes/No Prostate
Yes/No Thyroid
Yes/No Tonsils/ Adenoids Yes/No Tubal Ligation Yes/No Vasectomy
ANY ADDITIONAL SURGERIES NOT
LISTED:_____

ANESTHESIA HISTORY: ___ None __ Nausea/Vomiting __ Difficulty Awakening ___ Family History Anesthetic Complication __ Malignant Hyperthermia ___ Difficult Airway

PATIENT'S NAME: _____ DOB: ____ AGE:____

MEDICATIONS: List all medications including blood thinners (Plavix, Coumadin, aspirin, etc.). Please include Dose, Frequency, and Reason for Taking:
PLEASE CIRCLE "SEE LIST" IF LIST HANDED TO OFFICE STAFF

_____

_____

_____

ALLERGIES: Please list allergies below, with reaction. If no allergies, please check:
None____ _____
Latex Allergy: YES/NO Reaction:_____

SOCIAL HISTORY:
Tobacco----Smoker YES/NO ___packs/day for ____#of years
Previous smoker – when did you quit? _____ Do you Vape __

Alcohol Use ___Social ____Daily __ Quit __ years _N/A
Drugs _Marijuana __ Cocaine __ IV __ Other __N/A

FAMILY HISTORY: List any family members who have or have had any of the following:

Vascular disease_____
Cardiac disease_____
Stroke_____
Cancer_____
Kidney disease_____