Patient History Information

Please **complete all 4 pages** of this form. Your Surgeon will review the form with you during your appointment.

Name (last, MI, first) ______________________ **Date of Birth** ____________ **Age** ______

Primary Care Physician ______________________ **Physician who sent you to us** ____________

Reason for today's office visit ____

Location of the problem: ❑ Chest ❑ Arm ❑ Leg ❑ Abdomen ❑ Back Other: ______________	**Is there anything else occurring at the same time?** ❑ No ❑ Yes (please explain): ❑ Rash ❑ Nausea ❑ Headache ❑ Fever Other: ______________
On a scale of 1-10, with 10 being the worst, circle the number that best describes the problem: 1 2 3 4 5 6 7 8 9 10	**Is the problem constant or variable?** ❑ Dull then Sharp ❑ Very Sharp then leaves ❑ Constant Other: ______________
When did you first notice the problem? ❑ Today ❑ 2 days ago ❑ 2 weeks ago ❑ 1 month ago Other: ______________	**Does the problem interfere with your normal activities?** ❑ No ❑ Yes (please explain): ______________
Does anything help or make the problem worse? ❑ Moving around ❑ Standing up ❑ Lying on the side Other: ______________	**How long does the problem last?** ❑ 30 minutes ❑ 1 hour ❑ It is always there Other: ______________

Current Physicians

	Name of Physician	Phone #	Fax #
Referring Provider			
Primary Care			
Cardiologist			
Pulmonologist			
Oncologist			

Medical History

Place a check ✓ if you have ever been diagnosed with the following conditions:

Yes		Yes	
	Abdominal aortic aneurysm		Heart catheterization, when:
	Acid indigestion, reflux (GERD)		Heart/ Coronary angioplasty, when:
	Asthma		Heart rhythm problem, type:
	Anemia, low blood count		Hepatitis
	Antibiotic resistant infection (MRSA)		Hiatal hernia
	Anxiety		High blood pressure, since:
	BPH Prostate problems, enlargement		HIV/AIDS
	Carotid artery blockage (neck artery) ❑ Right ❑ Left ❑ Both		Kidney failure/insufficiency, since:
	Chest pain/ angina, since:		Kidney stones
	Colitis		Parkinson’s disease
	Congestive heart failure, when:		Pregnancies, #:
	Cancer – type(s):		Stomach ulcer
	Depression		Stroke/mini stroke, ❑ with paralysis ❑ without paralysis
	Diabetes, since: ❑ Insulin ❑ Pills ❑ Diet		TB exposure
	Emphysema (COPD)		Thyroid: ❑ Too much hyperthyroidism ❑ Low- hypothyroidism
	Gout		High Cholesterol
	Heart attack, when:		Other:

Medications

List all medications you currently take (including other medications, vitamins and herbs):

Name of Medications	Dose	# of Doses/Day	Name of Medications	Dose	# Doses/Day
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

Medication Allergies/Reactions

List all medications you have had a reaction or allergy to and describe:

Name of Medications	Allergy/reaction to medication
1.	
2.	
3.	
4.	

Surgical History Provide the year that you have had any of the following procedures (Cont. on the next page)

Yes		Yes	
	Abdominal aortic aneurysm		Hysterectomy ❑ Subtotal ❑ Total
	Appendectomy		Internal cardiac defibrillator (AICD or ICD)
	Breast: ❑ Biopsy ❑ Enlargement ❑ Lumpectomy		Knee replacement ❑ Right ❑ Left
	Breast removal for cancer ❑ Right ❑ Left ❑ Both		Lung Surgery
	Carotid Artery Surgery (neck) ❑ Right ❑ Left ❑ Both		Pacemaker surgery
	Coronary artery bypass		Prostate surgery (TURP)
	Cataract removal ❑ Right ❑ Left ❑ Both		Thyroid gland removal ❑ Partial ❑ Total
	Gallbladder removed		Varicose vein stripping ❑ Right ❑ Left ❑ Both
	Heart valve surgery		Other abdominal surgery
	Hemorrhoid surgery		Other abdominal surgery
	Hernia repair		Other vascular surgery (i.e. blood vessel repair)
	Hip replacement ❑ Right ❑ Left		Other surgery:

Social History/Risk Factors Place a check ✓ for all of the following that currently apply to you:

Yes		Yes	
	Alcohol: # of drinks ____ per day/week/month		Smoke cigars
	Alcohol type: ❑ Beer ❑ Wine ❑ Hard Liquor		Smoke pipe
	Never used tobacco		Use street drugs Types:
	Used to use tobacco, but quit When:		Get regular exercise (3 or more times per week)
	Smoke cigarettes		Marital Status: ❑ S ❑ M ❑ D ❑ W
	Chew tobacco		Occupation: Retired: ❑ Yes ❑ No

Family History Provide age of each family member (in the first 2 lines), and place a check ✓ if the family member had or currently has any of the following conditions:

	Mother	Father	Brothers	Sisters
Age if alive				
Age when deceased				
Aneurysm				
Cancer				
Diabetes				
Heart disease				
High blood pressure				
Stroke				

Other family medical problems: ______________________________

Review of Symptoms Place a check ✓ next to any symptom you have had in the **past six (6) months:**

GENERAL
- ❑ Normal
- ❑ Wt loss? Lbs ______ Since ______
- ❑ Wt gain? Lbs ______ Since ______
- ❑ Fever/Chills
- ❑ Fatigue
- ❑ Night Sweats
- ❑ Other

EYES/ENT
- ❑ Normal
- ❑ Vision loss/Eyepain
- ❑ Hearing loss
- ❑ Sore throat/Hoarseness
- ❑ Ear Infection
- ❑ Sinus infections
- ❑ Other

NEUROLOGICAL
- ❑ Normal
- ❑ Headaches
- ❑ Weakness
- ❑ Confusion
- ❑ Stroke/Temporary Paralysis
- ❑ Tremors/Seizures
- ❑ Other

RESPIRATORY
- ❑ Normal
- ❑ Short of breath lying flat
- ❑ Short of breath at rest
- ❑ Short of breath with exercise
- ❑ Wheezing
- ❑ Dry cough
- ❑ Cough with sputum
- ❑ Cough up blood
- ❑ Other

CARDIOVASCULAR
- ❑ Normal
- ❑ Irregular heart beat
- ❑ Racing heart
- ❑ Chest discomfort/pain
- ❑ Blackouts/passing out
- ❑ Heart murmur
- ❑ Pulmonary embulus (PE)
- ❑ Varicose Veins
- ❑ Other

INTEGUMENTARY
- ❑ Normal
- ❑ Rash
- ❑ Itching
- ❑ Skin lesions
- ❑ Finger/toenail problem
- ❑ Profuse sweating
- ❑ Other

GENITOURINARY
- ❑ Normal
- ❑ Prostate enlargement
- ❑ Urinate frequently
- ❑ Urinary incontinence
- ❑ Bladder infections
- ❑ Kidney failure
- ❑ Blood in urine
- ❑ Other

HEMATOLOGIC
- ❑ Normal
- ❑ Easy bruising
- ❑ Bloody nose
- ❑ Swollen lymph nodes
- ❑ Bleeding problems
- ❑ Blood clots, vein clots, milk leg
- ❑ Vein clots
- ❑ Other

PSYCHIATRIC
- ❑ Normal
- ❑ Depression
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Thoughts of suicide
- ❑ Other

MUSCULOSKELETAL
- ❑ Normal
- ❑ Arthritis
- ❑ Back pain
- ❑ Leg swelling
- ❑ Arm swelling
- ❑ Varicose veins
- ❑ Leg ulcers (sores)
- ❑ Neck pain
- ❑ Leg cramping/discomfort
- ❑ Foot pain at night
- ❑ Weakness
- ❑ Extremity pain
- ❑ Other

GASTROINTESTINAL
- ❑ Normal
- ❑ Jaundice/liver problem
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Constipation
- ❑ Indigestion/reflux
- ❑ Heartburn
- ❑ Difficulty swallowing
  - ❑ Liquids
  - ❑ Solids
- ❑ Lack of appetite
- ❑ Other

ENDOCRINE
- ❑ Normal
- ❑ Hyperthyroidism (over active)
- ❑ Hypothyroidism (under active)
- ❑ Hot flashes
- ❑ Diabetes
- ❑ Other

Patient Signaure ____ **Date** ______________________

"Review of symptoms" information reviewed and confirmed with patient; all others reported as negative