Medical History for Vascular Services

NAME: _____ APPOINTMENT DATE: _____

DOB _____ AGE_____ SEX ☐ Male ☐ Female MARITAL STATUS ☐ M ☐ S ☐ D ☐ W

YOUR SYMPTOMS CHECK ALL THAT APPLY TO YOU							
	Aching/Pain in legs		Leg Cramps		Leg pain with exertion		Skin discoloration
	Numbness/Tingling		Swelling		Ulcerations/Sores on Legs		Itching/Burning
	Throbbing		Restless legs		Varicose or spider veins		Stroke/TIA
	Weakness in arms/legs		Tired, heavy feeling in legs		Lower back/abdominal pain		Constipation
	Diarrhea		Change in eating habits		Unintentional weight loss		Vision loss/changes
	Other						

PATIENT MEDICAL HISTORY CHECK ALL THAT APPLY TO YOU							
	Pneumonia		Tuberculosis		Rheumatic Fever		Heart Disease
	High Blood Pressure		Kidney Disease		Bowel Disease		Anemia
	Diabetic		Stroke		Seizure/Convulsions		High Cholesterol
	Asthma		Arthritis		Bleeding Disorders		

SURGICAL HISTORY	
Surgery	Date/Year

MEDICATION ALLERGIES	
Medication	Allergic Reaction

MEDICATIONS - INCLUDE DRUG NAME, STRENGTH AND DOSAGE			

FAMILY MEDICAL HISTORY				PERSONAL HABITS					
	Father	Mother	Sibling		YES	NO	PREVIOUS	AMOUNT PER DAY	NUMBER OF YEARS
Stroke				Do you drink alcohol?					
Arthritis				Do you smoke?					
Stroke				Do you use drugs?					
Diabetes				Pharmacy of choice:					
Heart Disease									
Cancer									