PACIFIC VASCULAR SPECIALISTS

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ______________________________ **DOB:** ______________ **DATE:** ______________

Referring Doctor: ______________________________ Primary Care Physician: ______________________________

Current Age: __________ Weight: __________ Height: __________ Sex: M F

Reason for your visit: ____
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MEDICAL HISTORY – Have you been diagnosed with any of the following:

High blood pressure	YES	NO	Stroke	YES	NO	Bleeding problems	YES	NO
High cholesterol	YES	NO	Respiratory problems	YES	NO	Blood clot(s)	YES	NO
Heart attack	YES	NO	Diabetes	YES	NO	DVT	YES	NO
Heart surgery	YES	NO	Kidney Failure	YES	NO	Cancer	YES	NO

Other Chronic Medical Problems: ____
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____

PREVIOUS SURGERIES - Please list approximate date: ____
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SOCIAL HISTORY

Tobacco use:

- □ Never smoked
- □ Current smoker Packs/day: __________ Years smoked: __________
  - □ Light smoker
  - □ Heavy smoker
- □ Previous smoker Packs/day: __________ Years smoked: __________ Year quit: __________

Alcohol use: YES NO Type: ______________ Frequency: ______________________________

Exercise: YES NO Type of exercise: ____

ALLERGIES TO MEDICATIONS: ____
____

CURRENT MEDICATIONS: (Including prescription, non-prescription, and alternative medications)

Name	Dosage	Frequency
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________
______________________________	______________	______________________________

____ ____________________ ____________________________________

REVIEW OF SYSTEMS – Please circle YES or NO

Constitutional			**Ears, Nose, Mouth, Throat**			**Eyes**		
Good general health	YES	NO	Hearing loss or ringing	YES	NO	Wear glasses/contacts	YES	NO
Recent weight change	YES	NO	Sinus problems	YES	NO	Blurred/double vision	YES	NO
Night sweats, fevers	YES	NO	Nose bleeds	YES	NO	Eye disease or injury	YES	NO
Fatigue	YES	NO	Sore throat/voice change			Glaucoma	YES	NO
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	YES	NO	Shortness of breath	YES	NO	Nausea/vomiting	YES	NO
Palpitations	YES	NO	Cough	YES	NO	Abdominal pain	YES	NO
Heart trouble	YES	NO	Wheezing/asthma	YES	NO	Rectal bleeding	YES	NO
Swelling hands/feet	YES	NO	Coughing up blood	YES	NO	Bowel problems	YES	NO
Musculoskeletal			**Neurological**			**Integumentary**		
Muscle pain or cramps	YES	NO	Frequent headaches	YES	NO	Change in hair/nails	YES	NO
Stiffness/swelling	YES	NO	Paralysis or tremors	YES	NO	Rashes or itching	YES	NO
Joint pain	YES	NO	Convulsions/seizures	YES	NO	Breast lump	YES	NO
Trouble walking	YES	NO	Numbness/tingling	YES	NO	Breast pain/discharge	YES	NO
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urine	YES	NO	Bruise easily	YES	NO	Food allergies	YES	NO
Thyroid disease	YES	NO	Slow to heal	YES	NO	Aspirin allergies	YES	NO
Hormone problem	YES	NO	Enlarged glands	YES	NO	Antibiotic allergies	YES	NO
Genitourinary – MALE			**Genitourinary – FEMALE**			**Psychiatric**		
Blood in urine	YES	NO	Blood in urine	YES	NO	Insomnia	YES	NO
Kidney stones	YES	NO	Kidney stones	YES	NO	Confusion/memory	YES	NO
Difficulty voiding	YES	NO	Frequent urination	YES	NO	Depression	YES	NO
Testicle pain	YES	NO	Incontinence	YES	NO			

FAMILY MEDICAL HISTORY – Please list medical problems in your blood relatives:

Father: ________________________________ Mother: ________________________________

Brother(s): ______________________________ Sister(s): ________________________________

Son(s): ________________________________ Daughter(s): ______________________________

Do you have an Advanced Directive or POLST? YES NO

If yes, where is it located? ____

If you are diabetic, when was the date of your last eye exam? ________________________________

If you are age 50-75, when was the date of your last colonoscopy? ______________________________

If you are 65 years or older, when was the date of your last pneumonia vaccine? ________________________

If you are 65 or older, have you fallen in the last 3 months? YES NO

Preferred Pharmacy: ____

Name Address Phone #

Additional information you would like to share with the doctor: ________________________________

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