Name: _____

Date of Birth:_____

VASCULAR SURGERY ASSOCIATES
Your first choice for vascular care

Review of Systems Please review the following symptoms and circle those items that are a problem for you.		
General	Fatigue Weight loss Weight gain Fever Persistent infection	None
Eyes	Visual disturbance Glasses/contacts	None
Ear, Nose, Throat	Hearing loss Seasonal allergies Sinus pain Oral ulcers	None
Cardiovascular	Color changes in hands/feet non-healing wound/ulcer pain in legs Leg pain when walking numbness in legs swelling in legs chest pain palpitations shortness of breath difficulty breathing on exertion	None
Respiratory	Difficulty breathing wheezing chronic cough coughing up blood	None
Breast	Mass/lump breast pain nipple discharge	None
Gastrointestinal	Nausea vomiting abdominal pain	None
Musculoskeletal	Joint pain muscle pain muscle weakness	None
Skin	New sore/lesion skin ulcer	None
Neurologic	Fainting decreased memory numbness trouble walking seizure headaches	None
Psychiatric	Frequent crying depression anxiety fearful	None
Heme/Lymphatic	Easy bruising excessive bleeding gland problems	None

Health Maintenance Please list the most recent dates of your vaccines.			
	Month/Year		Month/Year
Flu vaccine		Pneumonia 23	
Shingles		Prevnar 13	

Family Health History Please list the health history of your first degree relatives.			
	Health problem(s)		Health Problem(s)
Father		Brother(s)	
Mother		Sister(s)	

Social History	
Are you a current smoker?	Do you drink alcohol?
Are you a former smoker?	Do you use illegal drugs?
Are you exposed to second hand smoke?	Are you concerned that you may have been exposed to HIV?
Do you exercise?	Type of exercise:

VASCULAR SURGERY ASSOCIATES
Your first choice for vascular care

Past Surgical Procedures/Hospitalizations			
Operation/Hospitalization	Month/Year	Operation/Hospitalization	Month/Year

Past Medical History Please list any medical conditions you have had or are being treated for.	
□ No pertinent past medical history.	
Condition/Disease	Condition/Disease
□ Hypertension	Other(s):
□ High Cholesterol	
□ COPD/Asthma/Emphysema	
□ Diabetes	
□ GERD/Reflux	
□ Depression or Anxiety	
□ Abdominal aortic aneurysm	
□ Blood transfusion(s)	
□ Deep vein thrombosis/blood clots	
□ Heart problems	
□ Kidney disease	
□ Liver disease	
□ Migraines	
□ Peripheral artery disease	
□ Cerebrovascular accident/Stroke	
□ Ulcers	