

Western Vascular Institute, PLLC

PATIENT HEALTH CHECKLIST

Patient Name: _____ Date of Birth: _____

Primary Care Doctor: _____

Please indicate whether you have experienced any of the following...

No Changes

General

- Fever
- Chills
- Sweats
- Anorexia
- Fatigue
- Weight loss

ENT

- Blurred or double vision
- Vision Loss
- Cataracts
- Ear Ringing
- Diminished Hearing

Cardiovascular

- Chest discomfort
- Skipped heartbeats
- Swelling in ankles or feet
- Fluttering feeling in chest

Respiratory

- Shortness of breath
- Chronic cough
- Asthma
- Wheezing

Gastrointestinal

- Indigestion
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Abdominal pain
- Ulcers

Genitourinary

- Loss of bladder
- Blood in urine

Musculoskeletal

- Arthritis
- Back pain
- Joint Pain
- Muscle weakness

Skin

- Skin rash
- Itching
- Dryness
- Suspicious Lesions
- Ulcer
- Lesion

Neurological

- Memory loss
- Seizures
- Vertigo
- Weakness
- Stroke

Extremities

- Edema
- Open Ulcers
- Gangrene
- Discoloration

Psychological

- Depression
- Anxiety
- Memory Loss
- Unusual stress

Endocrine

- Cold intolerance
- Heat intolerance
- Excessive thirst

Hematology/Lymphatic

- Breast masses/Lumps
- Enlarge lymph nodes
- Unexplained bruising

Allergy/Immunologic

- Hay fever
- Dust/pollen Allergies
- Persistent infections