

Western Vascular Institute, PLLC
Patient History Form

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Person Recording Information: _____ Relationship to Patient: _____

Current Medications and Allergies

Drug	Dosage (mg)	How many times daily?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES:

Other ALLERGIES:

Please indicate if you have had any of the following by marking the corresponding check box.

Past Medical History

Cancer

Cancer (specify type below)

Cancer Treatment (specify below)

Heart Disease

- Heart Disease
- Stroke
- High Blood Pressure
- High Cholesterol

Ear, Nose, Throat

- Ear, nose, throat problems
- Eye Disease
- Hearing Impaired

Skin

Skin Disease

Musculoskeletal

- Arthritis
- Osteoporosis

- Chronic Back Pain
- Growth/Development Disorder

Endocrine

- Diabetes
- Thyroid Disease
- Autoimmune Disorder
- Kidney Disease

Respiratory

- Asthma
- Chronic Lung Disease
- TB

Neurological

- Neurological Disease
- Epilepsy
- Chronic Headaches

Psychiatric

- Psychiatric Illness
- Depression

Other

- Anemia
- Bleeding Disease
- Blood Transfusion

Past Surgical History

Cardiac Surgery

- Heart Bypass
- Pacemaker
- Cardioversion
- Mitral Valve Replacement
- Other Cardiac Surgery:

Lung Surgery

Lung Surgery

Musculoskeletal Surgery

- Orthopedic Surgery
- Back Surgery
- Shoulder Surgery
- Foot Surgery
- Knee Surgery

Genitourinary Surgery

- Genitourinary Surgery
- Renal Surgery
- Prostate Surgery
- Vasectomy

Gastrointestinal Surgery

- Gastrointestinal Surgery
- Ulcer Surgery
- Appendectomy

- Colectomy
- Cholecystectomy
- Hernia Surgery
- Hemorrhoidectomy

***Woman Only**

- GYN Surgery**
- Hysterectomy**
- Uterine Surgery**
- Lumpectomy**
- Mastectomy**
- Breast Reduction**
- Ovary Removal**
- Tubal Ligation**

Vascular

- Carotid Surgery
- Aneurysm Surgery
- Angioplasty/Stents
- Amputation

Other Vascular Surgery:

DIFFICULTY WITH ANESTHESIA OR SURGERY? NO YES (please explain)

Family Medical History

If you have a family history of any of the following, please indicate which family member in the space provided.

Cancer-

- Colon Cancer: Who? _____
- Lung Cancer: Who? _____
- Ovarian Cancer: Who? _____
- Breast Cancer: Who? _____
- Skin Cancer: Who? _____
- Prostate Cancer: Who? _____

Heart Disease-

- Heart Disease: Who? _____
- Stroke: Who? _____
- CAD: Who? _____
- Hypertension: Who? _____
- Hyperlipidemia: Who? _____

Diabetes/Renal-

- Diabetes: Who? _____
- Renal Disease: Who? _____

Respiratory-

- Asthma : Who? _____
- Allergies: Who? _____
- COPD: Who? _____

Psych/Social-

- Psychiatric Problems: Who? _____
- Depression: Who? _____
- Substance Abuse: Who? _____

Other-

- Osteoporosis: Who? _____
- Anemia: Who? _____
- Arthritis: Who? _____
- Thyroid Disease: Who? _____
- Eye Problems: Who? _____

Other:

Social History

Occupation:

Marital Status:

History of Smoking-

- Yes No

Smoking Status-

- Active Packs/Day: _____
- Quit Year quit: _____

History of Drinking-

- Yes No

Alcohol frequency-

- Frequently
- Occasionally
- On a Social Basis

Other Social History Comments:

I have filled this form out to the best of my ability and accuracy. I understand that this form will be used to establish my past medical history in my chart.

Patients Signature: _____ **Date:** _____