VITAL

HEART & VEIN

PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

Social Security #: _____ Referring Physician: _____

Reason for Referral: _____

PHYSICIANS List all doctors providing care

Doctor's Name	Type of Doctor Primary Care, Surgeon, Urologist, etc.	Reason for Seeing This Doctor

ALLERGIES Do you have allergies to drugs, food, seafood, latex, or dye? ☐ YES ☐ NO

Allergy to	Reaction - rash, shortness of breath, hives, itching, etc.

CURRENT MEDICATIONS

List all vitamins, prescription medications, and over-the-counter medications.

Bring ALL medications in their original containers to every appointment.

Medication Name	Dosage	How often do you take?

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Name: _____

PAST MEDICAL & SURGICAL HISTORY

EENT
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Sinusitis
- ☐ Tinnitis (Ears Ringing)
- ☐ Tonsilitis

Respiratory
- ☐ ARDS (Adult Resp. Distress Syndrome)
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolus (Clot)
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea, CPAP
- ☐ Tuberculosis

Cardiac
- ☐ Arrhythmias
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Sudden Death
- ☐ Valvular Heart Disease

Vascular
- ☐ Aortic Aneurysm
- ☐ Carotid Disease
- ☐ Claudication
- ☐ DVT
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Raynaud's
- ☐ Varicose Veins

Gastrointestinal
- ☐ Cirrhosis
- ☐ GERD
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis

Renal/GU
- ☐ Bladder Cancer
- ☐ BPH (Enlarged Prostate)
- ☐ End Stage Renal Disease
- ☐ Kidney Stones
- ☐ Prostate Cancer
- ☐ Prostatitis
- ☐ Renal Artery Stenosis
- ☐ Renal Failure
- ☐ Renal Insufficiency

GYN
- ☐ Benign Breast Lump
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Ovarian Cancer

Musculoskeletal
- ☐ Back Pain
- ☐ Gout
- ☐ Lupus
- ☐ MVA Trauma
- ☐ Rheumatoid Arthritis

Skin
- ☐ Cellulitis
- ☐ Hives
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Skin Cancer

Neurologic
- ☐ Alzheimer's Disease
- ☐ CVA
- ☐ Dementia
- ☐ Diabetic Neuropathy
- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Syncope
- ☐ TIA

Psychiatric
- ☐ Alcoholism
- ☐ Anorexia
- ☐ Bipolar Disorder
- ☐ Chronic Anxiety
- ☐ Depression
- ☐ Panic Disorder
- ☐ Post-Traumatic Stress Disorder

Hematologic
- ☐ Anemia

Infectious Disease
- ☐ Endocarditis
- ☐ HIV

Recent Hospitalizations
☐ Yes ☐ No

List Hospital/Date/Reason for Hospitalization:

_____

_____

_____

_____

Other:

_____

_____

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PAST MEDICAL & SURGICAL HISTORY CONT.

Cardiac Surgeries & Procedures

- ☐ Cardiac Cath — Year _____
- ☐ Cardioversion — Year _____
- ☐ Coronary Angioplasty/Stent — Year _____
- ☐ Coronary Artery Bypass — Year _____
- ☐ EP Study — Year _____
- ☐ ICD Placement — Year _____
- ☐ Pacemaker Implant — Year _____
- ☐ RF Ablation — Year _____
- ☐ Heart Valve Repair/Replaced — Year _____
- ☐ Other (List Below)
- _____ — Year _____
- _____ — Year _____
- _____ — Year _____
- _____ — Year _____

Other Surgeries & Procedures

- ☐ Aneurysm Repair — Year _____
- ☐ Appendectomy — Year _____
- ☐ Back Surgery — Year _____
- ☐ Carotid Surgery — Year _____
- ☐ Cholecystectomy (Gallbladder Removed) — Year _____
- ☐ Gastric Bypass — Year _____
- ☐ Hysterectomy — Year _____
- ☐ Kidney Stone Treatment — Year _____
- ☐ Knee Surgery — Year _____
- ☐ Mastectomy — Year _____
- ☐ Nephrectomy (Kidney Removed) — Year _____
- ☐ Tonsillectomy — Year _____
- ☐ Thyroidectomy — Year _____
- ☐ Other: _____ — Year _____

SOCIAL & FAMILY HISTORY

Alcohol Use

Do you consume alcohol?

☐ Yes ☐ No ☐ Former

Frequency: _____

Year Quit: _____

Smoking/Tobacco Use

Do you smoke/use tobacco?

☐ Yes ☐ No ☐ Former

Type: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Smokeless

Number of Years Smoked: _____

Packs Per Day: _____

Years Quit: _____

Passive Smoke Exposure

☐ Yes ☐ No

Diet

Are you on a special diet?

☐ Yes ☐ No ☐ Former

What type of diet? _____

Do you drink caffeine? ☐ Yes ☐ No

How much per day? _____

Do you eat much chocolate per day?

☐ Yes ☐ No

Exercise

Do you exercise regularly?

☐ Yes ☐ No

(minimum of 30 minutes; 3 times a week)

If YES, describe: _____

Religion:

Agree to Transfusion ☐ Yes ☐ No

Drug Use/Abuse

☐ Yes ☐ No ☐ Former

Substance Type: _____

Year Quit: _____

Marital Status: _____

Occupation: _____

☐ Unemployed ☐ Retired

Residence

Lives with: _____

☐ Nursing Home ☐ Assisted Living

Advanced Directives

☐ None ☐ DNR

☐ HC Proxy ☐ Living Will Date: ____

IS THERE A FAMILY HISTORY OF: (List All Family Members) Family History Unknown

Heart Attack	☐ Yes	☐ No	Family Member _____
Stroke	☐ Yes	☐ No	Family Member _____
Coronary Bypass Surgery	☐ Yes	☐ No	Family Member _____
Diabetes	☐ Yes	☐ No	Family Member _____
High Blood Pressure	☐ Yes	☐ No	Family Member _____
Coronary Artery Disease	☐ Yes	☐ No	Family Member _____
Sudden Death	☐ Yes	☐ No	Family Member _____

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SOCIAL & FAMILY HISTORY CONT.

REVIEW OF SYMPTOMS CHECK IF YOU ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED BELOW

General
- ☐ Decreased appetite
- ☐ Fever
- ☐ Chills
- ☐ Weight change (loss or gain)
- ☐ Night sweats
- ☐ Fatigue

HEENT
- ☐ Headache
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double vision
- ☐ Blurred vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds

Respiratory
- ☐ Persistent cough
- ☐ Shortness of breath with rest
- ☐ Shortness of breath with activity
- ☐ Snoring
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ # of pillows used to sleep on:

Hematological
- ☐ Bleed easily
- ☐ Bruise easily

Cardiovascular
- ☐ Chest pain, pressure, or tightness
- ☐ Passing out
- ☐ Heart palpitations
- ☐ History of blood clots or phlebitis
- ☐ Irregular heart beats
- ☐ Non-healing sores on legs or feet
- ☐ Pain in legs/hips with walking
- ☐ Short of breath lying flat
- ☐ Swelling of feet or ankles
- ☐ Waking up panicky & short of breath
- ☐ Dizziness

Gastrointestinal
- ☐ Nausea and vomiting
- ☐ Nausea without vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn/Indigestion
- ☐ Rectal bleeding
- ☐ Black tarry stools
- ☐ Difficulty swallowing solids/liquids

Neurological
- ☐ Headaches
- ☐ Numbness/tingling on one side
- ☐ Weakness on one side
- ☐ Difficulty speaking
- ☐ Loss of memory

Endocrine
- ☐ Excessive thirst
- ☐ Increased urination
- ☐ Hair loss

Musculoskeletal
- ☐ Muscle weakness
- ☐ Joint stiffness
- ☐ Arthritis
- ☐ Gout
- ☐ Muscle cramps

Genitourinary
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Frequency of urination
- ☐ Urgency of urination
- ☐ Incontinence

Males
- ☐ Difficulty starting stream
- ☐ Wake up at night to urinate
- ☐ History of urinary retention
- ☐ Prostate problems
- ☐ Erectile dysfunction

Females
Date of last menstrual period: _____
- ☐ Currently on birth control

Menopause: ☐ Yes ☐ No

Age at Menopause: _____

Patient Signature: _____ Date: _____

Signature of Person Completing Form: _____ Relationship: _____ Date: _____