

Vascular Specialists of Central Florida

TODAY'S DATE _____

NAME: _____ Date of Birth ____/____/____

I. HISTORY OF PRESENT ILLNESS:

Reason for today's visit _____

Have you had any lab tests or x-rays (MRI, CT-scan, etc) relating to today's complaint? Yes No

If yes, please list _____

II. PAST MEDICAL HISTORY: *Please circle all that apply to you and indicate date(s) of diagnosis*

Insulin Dependent Diabetes Date_____

Non-insulin Dependent Diabetes Date_____

Heart Disease Date_____

Heart Attack Date_____

Hypertension Date_____

Deep Vein Thrombosis Date_____

Stroke Date_____

Kidney Disease Date_____

Kidney Failure Date_____

Aneurysm (location _____) Date_____

Cancer (type(s) _____) Date_____

COPD (Asthma/Bronchitis/Emphysema) Date_____

Please list any other serious illnesses/diseases:

III. PAST SURGICAL HISTORY: *Please list any previous surgeries and the dates (more can be listed on the reverse of this page)*

IV. PAST CARDIAC HISTORY: *Please provide dates and results of the following:*

Date of most recent cardiac stress test _____ Passed? Yes No None

Date of most recent heart catheterization _____ Stents? Yes No Number of Stents _____

V. MEDICATION LIST: *Please include any vitamins, nutritional supplements and alternative medicines*

Medication Name	Dose (milligrams or milliliters)	How often (? times a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. ALLERGIES:

ARE YOU ALLERGIC TO IODINE? YES NO
ARE YOU ALLERGIC TO SHELLFISH? YES NO
DO YOU HAVE ANY ALLERGIES TO MEDICATION? YES NO

If yes, please list the medication and the type of reaction you have when you use it:

*****IN CASE OF A SURGICAL EMERGENCY, ARE YOU WILLING TO RECEIVE BLOOD OR BLOOD PRODUCTS? YES NO**

VII. REVIEW OF SYSTEMS: *Please circle current or recent symptoms you have experienced*

- General: fevers or chills
- Skin: color changes, itching, bruising, bleeding, rashes, open sores
- Lymph nodes: enlarged or painful glands in: neck, groin or underarms
- Hematology/Immune: anemia, recent bleeding, blood clots, recurrent infections
- Musculoskeletal: arthritis, painful or swollen joints, osteoarthritis, muscle weakness or wasting, cramps, leg or back pain, leg swelling
- Head and neck: headache, vertigo, fainting spells, head trauma visual changes
- Respiratory: shortness of breath, cough, wheezing, sputum production
- Cardiovascular: palpitations, irregular heartbeat, chest pain
- Gastrointestinal: nausea, vomiting, abdominal pain, diarrhea
- Neurological: slurred speech, weakness, numbness or tingling, balance problems, coordination problems or seizures

Are you experiencing any pain now? Yes No If so, where is the pain _____

No pain.....some pain.....very painful

Level of the pain 0 1 2 3 4 5 6 7 8 9

VIII. FAMILY HEALTH HISTORY: *If you are adopted skip this section and proceed to the next section.*

Please circle all that applies to your parents:

Mother: Blood clots, diabetes, cancer, heart disease, stroke, aneurysm

Father: Blood clots, diabetes, cancer, heart disease, stroke, aneurysm

Siblings: Blood clots, diabetes, cancer, heart disease, stroke, aneurysm

IX. SOCIAL HISTORY:

Occupation _____ Marital Status _____

Children (gender/age) _____

Do you exercise routinely: Yes No If so, what activity? _____ hours /week? _____

Do you use alcohol? Yes No Have you ever used alcohol in the past? Yes No

Frequency of use _____ Amount _____

Do you use tobacco? Yes No How much _____ How often _____

Have you used tobacco in the past? Yes No Years of use _____ When did you quit? _____