VASCULAR SURGERY ASSOCIATES, L.L.C.
Medical History

Name: _____

Date of Birth: _____ Age: _____

Date: _____ Initials: _____

Date: _____ Initials: _____

Date: _____ Initials: _____

HPI: (Physician Use Only)

Medical History:	Yes	No
Heart Disease		
High Blood Pressure		
High Cholesterol		
Diabetes		

Family Medical History:	Yes	No	Relation
Stroke			
Aneurysms			
Heart Disease			

Social History:	Yes	No
Do you smoke?		
If you quit smoking, what year?		
Do you drink alcohol?		
If so, how often?		
Are you married?		
Occupation:		

Past Surgical History:	Yes	No
Heart Artery Stent or Bypass		
Arm or Leg Stent or Bypass		

All Allergies:	Yes	No
Iodine		
Contrast Dye		
Latex		
Shellfish		

Review of Systems:	Yes	No
Neurologic Disorder (Stroke, Seizure)		
Psychiatric Disorder (Depression, etc)		
Visual Changes or Other Eye Problems		
Ears, Nose or Throat Disease		
Lung Diseases (Pneumonia, COPD)		
Intestinal Disorder (Reflux, Ulcers, etc)		
Liver Disorders		
Kidney or Bladder Disorders		
Female Organ Diseases		
Arthritis or Skeletal Disorders		
Skin Diseases (Moles, Rashes, Ulcers)		
Cancer (Any Type)		
Anemia or other Blood Disorders or Diseases		

Please describe any disease or disorder you have answered yes to:

_____

_____

Medication and Dosage:
