Artery and Vein Institute, LLC

PATIENT HISTORY

TODAY'S DATE:_____

PATIENT'S NAME: _____ DOB: ____ AGE:

Referring Physician: _____

Primary Care Physician (family doctor): _____
Physicians you wish to receive reports: _____

REASON FOR TODAY'S VISIT:_____

MEDICAL HISTORY:

Do you have or have you ever had known vascular disease? If yes, what type? Arterial _____ Venous ____

__ Emphysema/COPD

__Asthma

__ Sleep Apnea _ CPAP

___Heart Attack

___ Congestive Heart Failure

___Artificial Heart Valve

__ Coronary Artery Disease

___Atrial Fibrillation

__ Arrhythmia (Irregular heartbeat)

__Pacemaker

___Defibrillator

__ Hypertension (High Blood Pressure)

__ Hypercholesterolemia (High Cholesterol)

__Depression/Anxiety

__Diabetes __Diet__ Pills __Insulin

__ Hypothyroid (underactive)

__Stroke

__TIA

__DVT

__Carotid stenosis

__Aneurysm

__IBS/ GERD

__Bleeding disorder

__IBS/Crohn's Disease

__Kidney disease __w/dialysis

__HIV/AIDS

__Seizure disorder

___Multiple Sclerosis

Artery and Vein Institute, LLC 2

Patient Name:_____Date of birth:_____

Surgical History:

Yes/No Appendectomy

Yes/No Vascular Surgical Intervention_R_L

Yes/No Mastectomy_ R _ L

Yes/No Cholecystectomy (Gallbladder) __ _ Yes/No Colonoscopy

Yes/No Colon/Rectal Surgery

Yes/No C-Section

Yes/No Gastric Bypass/Sleeve

Yes/No Heart Bypass (CABG)

Yes/No Heart Stents

Yes/No Heart Valve Replacement __ _ Yes/No Hernia Repair

Yes/No Hysterectomy

Yes/No Joint Replacement

Which Body Part?_____

Yes/No Prostate

Yes/No Thyroid

Yes/No Tonsils/ Adenoids Yes/No Tubal Ligation Yes/No Vasectomy

ANY ADDITIONAL SURGIES NOT LISTED:_____

Artery and Vein Institute, LLC 3

Patient Name:_____Date of birth:_____

ANESTHESIA HISTORY: ___ None __ Nausea/Vomiting __ Difficulty Awakening ___ Family History Anesthetic Complication __ Malignant Hyperthermia ___ Difficult Airway

FAMILY HISTORY: List any family members who have or have had any of the following:

Vascular disease_____
Cardiac disease_____
Stroke_____
Cancer_____

SOCIAL HISTORY:
Tobacco----Smoke__packs/day for __years __Quit ___ Years
___ Vape __ N/A
__ Alcohol _Social _Daily __ Quit __ years Drugs _Marijuana __ Cocaine __ IV __ Other

REVIEW OF SYMPTOMS:

Ear/Nose/Throat:
__ None
__ Hearing loss/hearing aid
__ Difficulty swallowing/opening mouth

Pulmonary:
__None
__Shortness of breath

Constitution:
___Weight loss
___Weight gain/loss
___Fatigue

Genitourinary:
__None
__UTI's
__Enlarged prostate

Artery and Vein Institute, LLC 4

Patient Name:_____Date of birth:_____

Cardiovascular:
___Chest pain/angina
___Heart murmur
___CHF
___High blood pressure
___High cholesterol
___Low blood pressure

Pulmonary:
__Shortness of breath
__Cough/wheezing
__Swelling

Gastrointestinal:
__Hemorrhoids
__Change in bowel habits
__Nausea or vomiting
__Constipation/diarrhea
__GERD

Skin:
__Rash/lesions
__Cancer

Musculoskeletal:
__Joint pain
__Muscle disorder
__Back pain

Neurologic:
__Fainting/Seizures
__Migraines
__Paralysis

Artery and Vein Institute, LLC 5

Patient Name:_____Date of birth:_____

MEDICATIONS: List all medications including blood thinners (Plavix, Coumadin, aspirin, etc.). Please include Dose, Frequency, and Reason for Taking:

PLEASE CIRCLE "**SEE LIST**" IF LIST HANDED TO OFFICE STAFF

_____

_____

ALLERGIES: Please list allergies below, with reaction. If no allergies, please check: None____

_____

_____

LATEX ALLERGY: YES/NO

REACTION:_____

STAFF ONLY:

HT: **LOCATION:**

Quality:

WT: **Severity:**

Duration:

BP: **Other:**

Reviewed with patient by _____