Northwest Vascular Consultants, Inc.

Vascular Surgery

Today's Date:____________

Patient History Questionnaire

Patient name:____ Birth date: ____________ Age: _________

Referring physician:____

Any/All other doctors you see:____

Reason for your visit:____

For Office Use only- Check the entry furthest to the right for HP1	Brief 1-3 elements	Brief 1-3 elements	Extended 4 + or 3 inactive	Extended 4 + or 3 inactive

HISTORY OF PRESENT ILLNESS (HP1)

◊ Location: ________________________________
(Where on the body symptom occurs)

◊ Duration: ______________________________
(How long have you had symptom? How long does it last?)

◊ Severity: ________________________________
(Severe, worse, slightly. Pain scale 1-10)

◊ Quality: ________________________________
(Character of symptom…burning, gnawing, stabbing)

◊ Timing: _________________________________
(When symptoms occur)

◊ Context: ________________________________
(Situation associated with symptom)

◊ Modifying Factors: ____
(Things to make symptoms better or worse)

◊ Associated Signs/Symptoms: ____
(Other things that happen when this symptom occurs)

For Office Use only				
Check entry furthest right for PFSH	None	None	1 or 2 HX areas	3 HX areas

Medical History: *Please circle* ***Yes*** *or* ***No*** *if you have a family history of any of the following medical problems.*

High Blood Pressure…….Yes No
Respiratory Problems……Yes No
Bleeding Problems………Yes No

Diabetes……Yes No
Stroke……….Yes No
Other Problems_______________________________________

Heart Trouble……..Yes No
Cancer……………..Yes No

____

Drug allergies: ____________________ ____________________ ____________________

What is your current weight? ______________

Current Medications: (please include dosage and frequency) ____________________

______________ ____________________ ____________________ ____________________

______________ ____________________ ____________________ ____________________

______________ ____________________ ____________________ ____________________

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

____ ____

____ ____

Patient History (Cont.)

Family History: *Please list any medical problems in your relatives.*

Father:________________________ Mother________________________ Siblings:________________________

Others:________________________ ________________________ ________________________

Social History: Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Tobacco Use: □ Never □ Quit/ When? _______ □ Smoker/ how much?_____________

Alcohol Use: □ Never □ Rarely □ Moderate □ Daily □ How much?___________

Drug Use: □ Never □ Type and frequency__________________________________

Occupation: __________________ Other: ____________________________________

For Office Use only				
Check entry furthest right for ROS	None	Pertinent- 1 System	Extended- 2-9 Systems	Complete-10 systems or some systems with all others negative

Review of Systems

*Please circle **Yes** or **No** if you have any of the following problems.*

◊ **Constitutional**
- Good General Health Yes No
- Recent weight change Yes No
- Night sweats, fevers Yes No
- Fatigue Yes No

◊ **Cardiovascular**
- Chest pain Yes No
- Palpitations Yes No
- Heart trouble Yes No
- Swelling hands/feet Yes No

◊ **Musculoskeletal**
- Muscle pain or cramps Yes No
- Stiffness/swelling joints Yes No
- Joint pain Yes No
- Trouble walking Yes No

◊ **Endocrine**
- Excessive thirst/urination Yes No
- Thyroid disease Yes No
- Hormone problem Yes No

◊ **Genitourinary –**Male only
- Blood in urine Yes No
- Kidney stones Yes No
- Sexual problems Yes No
- Testicle pain Yes No

◊ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing Yes No
- Sinus problems Yes No
- Nose bleeds Yes No
- Sore throat/voice change Yes No

◊ **Respiratory**
- Shortness of breath Yes No
- Cough Yes No
- Wheezing/asthma Yes No
- Coughing up blood Yes No

◊ **Neurological**
- Frequent headaches Yes No
- Paralysis or tremors Yes No
- Convulsions/seizures Yes No
- Numbness/tingling Yes No

◊ **Hematologic / Lymphatic**
- Bruise easily Yes No
- Slow to heal Yes No
- Enlarged glands Yes No

◊ **Genitourinary –**Female only
- Blood in urine Yes No
- Kidney stones Yes No
- Sexual problems Yes No
- Menstrual problems Yes No

◊ **Eyes**
- Wear glasses/contacts Yes No
- Blurred/double vision Yes No
- Eye disease or injury Yes No
- Glaucoma Yes No

◊ **Gastrointestinal**
- Nausea/vomiting Yes No
- Abdominal pain Yes No
- Rectal bleeding Yes No
- Bowel problems Yes No

◊ **Integumentary** (Skin/Breast)
- Change in hair or nails Yes No
- Rashes or itching Yes No
- Breast lump Yes No
- Breast pain/discharge Yes No

◊ **Allergic / Immunologic**
- Food allergies Yes No
- Aspirin allergies Yes No
- Antibiotic allergies Yes No

◊ **Psychiatric**
- Insomnia Yes No
- Confusion/memory loss Yes No
- Depression Yes No

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed______________________________________ Date_________________

Physician Statement: I have reviewed the questionnaire with the patient.

Signed______________________________________ Date_________________