PACIFIC VASCULAR SPECIALISTS

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____
Referring Doctor: _____ Primary Care Physician: _____
Current Age: _____ Weight: _____ Height: _____ Sex: ☐ M F ☐

Reason for your visit: _____
_____
_____

MEDICAL HISTORY – Have you been diagnosed with any of the following:

☐ High blood pressure	☐ Stroke	☐ Bleeding problems
☐ High cholesterol	☐ Respiratory problems	☐ Blood clot(s)
☐ Heart attack	☐ Diabetes	☐ DVT
☐ Heart surgery	☐ Kidney Failure	☐ Cancer

Other Chronic Medical Problems: _____
_____
_____

PREVIOUS SURGERIES - Please list approximate date: _____
_____
_____

SOCIAL HISTORY
Tobacco use:
- ☐ Never smoked
- ☐ Current smoker Packs/day: _____ Years smoked: _____
  - ☐ Light smoker
  - ☐ Heavy smoker
- ☐ Previous smoker Packs/day: _____ Years smoked: _____ Year quit: _____

Alcohol use: ☐ YES ☐ NO Type: _____ Frequency: _____
Exercise: ☐ YES ☐ NO Type of exercise: _____

ALLERGIES TO MEDICATIONS: _____
_____

CURRENT MEDICATIONS: (Including prescription, non-prescription, and alternative medications)

Name	Dosage	Frequency

_____ _____ _____

_____ _____ _____

REVIEW OF SYSTEMS – Please check boxes that apply

Constitutional
- ☐ Good general health
- ☐ Recent weight change
- ☐ Night sweats, fevers
- ☐ Fatigue

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing/asthma
- ☐ Coughing up blood

Eyes
- ☐ Wear glasses/contacts
- ☐ Blurred/double vision
- ☐ Eye disease or injury
- ☐ Glaucoma

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart trouble
- ☐ Swelling hands/feet

Ears, Nose, Mouth, Throat
- ☐ Hearing loss or ringing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat/voice change

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Rectal bleeding
- ☐ Bowel problems

Musculoskeletal
- ☐ Muscle pain or cramps
- ☐ Stiffness/swelling
- ☐ Joint pain
- ☐ Trouble walking

Neurological
- ☐ Frequent headaches
- ☐ Paralysis or tremors
- ☐ Convulsions/seizures
- ☐ Numbness/tingling

Integumentary
- ☐ Change in hair/nails
- ☐ Rashes or itching
- ☐ Breast lump
- ☐ Breast pain/discharge

Endocrine
- ☐ Excessive thirst/urine
- ☐ Thyroid disease
- ☐ Hormone problem

Hematologic/Lymphatic
- ☐ Bruise easily
- ☐ Slow to heal
- ☐ Enlarged glands

Allergic/Immunologic
- ☐ Food allergies
- ☐ Aspirin allergies
- ☐ Antibiotic allergies

Genitourinary – MALE
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Difficulty voiding
- ☐ Testicle pain

Genitourinary – FEMALE
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Incontinence

Psychiatric
- ☐ Insomnia
- ☐ Confusion/memory
- ☐ Depression

FAMILY MEDICAL HISTORY – Please list medical problems in your blood relatives:

Father: _____ Mother: _____

Brother(s): _____ Sister(s): _____

Son(s): _____ Daughter(s): _____

Do you have an Advanced Directive or POLST? ☐ YES ☐ NO

If yes, where is it located? _____

If you are diabetic, when was the date of your last eye exam? _____

If you are age 50-75, when was the date of your last colonoscopy? _____

If you are 65 years or older, when was the date of your last pneumonia vaccine? _____

If you are 65 or older, have you fallen in the last 3 months? ☐ YES ☐ NO

Preferred Pharmacy: _____

Name Address Phone #

Additional information you would like to share with the doctor: _____

_____

_____

_____