

**VIRGINIA VASCULAR CENTER**

**PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:**

**REASON FOR VISIT:** \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Does anything make the problem worse? \_\_\_\_\_

Does anything make the problem better? \_\_\_\_\_

Do you remember any incident which started the problem? \_\_\_\_\_

**CHECK THE BOX IF YOU HAVE (OR PREVIOUSLY HAD) THE FOLLOWING PROBLEMS:**

fever  chills  weight loss (how much? \_\_\_\_\_ over what period of time? \_\_\_\_\_)

headache  weakness  numbness  changes in speech  confusion  memory difficulty

anxiety  depression  rash (where? \_\_\_\_\_)  swelling (where? \_\_\_\_\_)  bruising

hearing loss  changes in vision  loss of vision  chest pain  heart racing (palpitations)

difficulty laying flat while sleeping (how many pillows do you use? \_\_\_\_\_)

shortness of breath  difficulty breathing when exerting oneself

difficulty breathing during the night  cough (productive or non-productive?)  coughing up blood

nausea  vomiting  constipation  diarrhea

bright red blood in stool  dark blood in stool (like coffee grounds)

increased frequency of urination  hesitancy  pain on urination  blood in urine

**SOCIAL HISTORY:**

SMOKING  Yes  No How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

ALCOHOL  Yes  No How many drinks per day? \_\_\_\_\_ How many years? \_\_\_\_\_

DRUGS \_\_\_\_\_ Types \_\_\_\_\_ How many years? \_\_\_\_\_

MARITAL STATUS:  Single  Married  Divorced  Separated

**FAMILY HISTORY:**

MOTHER –  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

FATHER –  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

MATERNAL GRANDMOTHER  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

MATERNAL GRANDFATHER  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

PATERNAL GRANDMOTHER  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

PATERNAL GRANDFATHER  Alive (any illnesses? \_\_\_\_\_)

Deceased (cause \_\_\_\_\_)

**PAST MEDICAL HISTORY (Any Previous Illnesses?):** \_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY (Any Previous Surgeries?)** \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES: (Medications, Foods, Pollen)** \_\_\_\_\_

What kind of reaction did you have? (rash, hives, difficulty breathing)

\_\_\_\_\_

**MEDICATIONS: (Include Dosage and Frequency, Prescription and Nonprescription)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_