Washington University in St. Louis

SCHOOL OF MEDICINE

VASCULAR HEALTH HISTORY FORM

Name: ____ [ ] M [ ] F Date of birth: ______________ Age: ___

Address: ____ SSN#: ______________

Home#: _________________________ Cell#: ___________________________ Work/Alt#: _________________

Nearest relative/emergency contact: ____________________________________ Relation to you: ______________

Home#: _________________________ Cell#: ___________________________ Work/Alt#: _________________

	Referring Physician	**Primary Physician**
Name/Specialty: Address: Phone: Fax:		

What brings you to the office today?

Please describe your symptoms (location, quality, severity, timing. exacerbating/relieving factors):

MEDICAL HISTORY: Have you ever been diagnosed or taking medications for the following?

[ ] Yes [ ] No High blood pressure
[ ] Yes [ ] No Heart/coronary stents
[ ] Yes [ ] No Heart disease
[ ] Yes [ ] No Heart attack
[ ] Yes [ ] No Heart failure
[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No High cholesterol/lipids
[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Lung problems (asthma/emphysema)
[ ] Yes [ ] No Kidney problems
[ ] Yes [ ] No Blood clots/DVTs
[ ] Yes [ ] No Cancers

List any other medical problems that your doctors have diagnosed:

SURGICAL HISTORY: Please list <u>all</u> operations (even if not vascular-related).

Date	Type of operation	Reason for operation	Hospital

MEDICATIONS: Please list all prescribed and over-the-counter drugs, supplement and vitamins. Include the drug name, dosage and frequency taken. (May attach separate sheet if necessary.)

ALLERGIES

Do you have any allergies to medicines, LATEX, IV dye, iodine or shellfish? [ ] Yes [ ] No [ ] Don't know
Have you received IV dye or contrast for an X-ray/CT /procedure before? [ ] Yes [ ] No [ ] Don't know
Please list any known allergies to medications and food, include reaction if known:

SOCIAL HISTORY:

Occupation: ___________________________ [ ] If retired, former occupation: __________________________
Smoking: [ ] Never [ ] Current (pks/day, years): _______________ [ ] Quit (pks/day, years): _____________
Alcohol: [ ] Never [ ] Yes: _____ # servings [ ] daily [ ] weekly [ ] monthly
Marital status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Other:
Who lives at home with you:

FAMILY HISTORY:

Does your family have a history of diseases of the aorta (including aneurysm, dissection)? [ ] Yes [ ] No
Please list any health problems of your parents, siblings and children (include age/cause of death if expired):

REVIEW OF SYSTEM: Please explain any "Yes" answer in the space provided.

General:			**Genitourinary:**		
Weight loss/gain	[ ] Yes [ ] No		Frequent urination	[ ] Yes [ ] No	
Loss in appetite	[ ] Yes [ ] No		Painful urination	[ ] Yes [ ] No	
Fatigue	[ ] Yes [ ] No				
HEENT:			**Musculoskeletal:**		
Vision changes	[ ] Yes [ ] No		Back pain	[ ] Yes [ ] No	
Temporary blindness	[ ] Yes [ ] No		Muscle weakness	[ ] Yes [ ] No	
Hearing loss	[ ] Yes [ ] No		Cramps w/walking	[ ] Yes [ ] No	
Respiratory:			**Hematologic:**		
Wheezing	[ ] Yes [ ] No		Anemia	[ ] Yes [ ] No	
Shortness of breath	[ ] Yes [ ] No		Easy bruisability	[ ] Yes [ ] No	
Cough	[ ] Yes [ ] No		Clotting disorders	[ ] Yes [ ] No	
Cardiovascular:			**Endocrine:**		
Chest pain	[ ] Yes [ ] No		Diabetes	[ ] Yes [ ] No	
Irregular heart beat	[ ] Yes [ ] No		Thyroid disorder	[ ] Yes [ ] No	
Gastrointestinal:			**Neurologic:**		
Abdominal pain	[ ] Yes [ ] No		Slurred speech	[ ] Yes [ ] No	
Diarrhea	[ ] Yes [ ] No		Weakness	[ ] Yes [ ] No	
Nausea/vomiting	[ ] Yes [ ] No		Facial droop	[ ] Yes [ ] No	

Is there any additional information you want to share?

Patient signature: ____ Date: __________

Physician signature: ____ **Date:** ______________