National Vascular Associates - History & Physical Form		
Pt Name:	ID#(office use)	DOB:

Current Medications

	Medication Name	Dose	Frequency	Route
1				
2				
3				
4				
5				
6				

Allergies:

Vaccines

Pharmacy

Name	Location	Phone #

Surgical History

Surgery	Date

Family History

Mother: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Father: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Brother: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Sister: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Social History

Does anyone in your house smoke cigarettes? □Yes □No

Do you smoke cigarettes? □Never Former: # years quit ______ Current: # of years___

Do you use any other forms of nicotine? If yes, what__________ Packs/week__

Packs/day___

Alcohol Use: □None□Occasionally □Moderate □Heavy #Years___

Illicit Drugs: □No □Yes Type:________________

Caffeine: □No □Yes Cups/day:____________

Exercise: □None □Occasionally □Moderate □Heavy

Diet: □Regular □Vegetarian □Gluten Free □Cardiac □Diabetic

Are you able to take care of yourself? □No □Yes

Do you have difficulty with any of the following?

□Walking □Climbing Stairs □Dressing □Bathing □Running Errands

Past Medical History-please check all that apply

□Asthma □AAA □Bleeding Disorder □Back Pain □Cancer □Coronary Artery Bypass

□COPD □Deep Vein Thrombosis □Diabetes □Heart Disease □High Blood Pressure

□HIV □Hepatitis □High Cholesterol □Kidney Disease □Impotence □Osteoarthritis

□Migraines □Patent Foramen Ovale (hole in heart) □Peripheral Artery Disease

□Pulmonary Embolism □Stroke □Vision Problems □Hearing Problems □Uterine Fibroids

□Hemorrhoids □Varicose Veins □Pelvic Congestion Syndrome □Skin Ulcerations

□Lymphedema □Other____

Current Problems- please check all that apply

□Leg pain □Leg swelling □Knee pain □Ulcerations □Skin discoloration □Shoulder pain

□Deep vein thrombosis □Peripheral Artery disease □Dizziness □Weakness □Passing out

□Fatigue □Vision Disturbances □Shortness of breath □Weight loss/gain

□Appetite: increase/decrease □Digestive problems □Urinary problems □Bowel problems

□Varicose veins □Bleeding hemorrhoids □Uterine Fibroids □Other____________________

The information in this form is complete to the best of my knowledge and I understand that the information given in this form is documented within my medical record.

Patient: ____

Date:__________________________

Guarantor: ____ Date:__________________________