

**VASCULAR & TRANSPLANT SPECIALISTS  
NEW PATIENT HISTORY, page 1 of 2**

\*Please take a few minutes to fill this form out completely and accurately\*

**Date:** \_\_\_\_\_ **SS #:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Other Physicians:** \_\_\_\_\_  
**Reason for Visit:** \_\_\_\_\_

**RESERVED FOR DOCTOR'S NOTES:**

LOCATION  
 QUALITY  
 SEVERITY  
 DURATION  
 TIMING  
 CONTEXT  
 MODIFIED BY  
 ASSOCIATED SX

\_\_\_\_\_ **MD Date**

**Past Medical History: Please indicate if you have ever had any of the following:**

	Yes		Yes
HIGH BLOOD PRESSURE		CANCER	
DIABETES: controlled by (circle) : diet, pills, insulin		LUNG DISEASE: asthma, emphysema, bronchitis	
HIGH CHOLESTEROL		FOOT ULCERS OR GANGRENE	
HIGH TRIGLYCERIDES		BLOOD CLOTS IN LEGS OR LUNGS	
THYROID DISEASE		LEG CRAMPS CAUSED BY WALKING	
HEPATITIS B OR C		ANEURYSM	
HIV OR AIDS		INJURY OR ACCIDENTS	
GERD : acid reflux or heartburn			
PEPTIC ULCERS: intestinal bleeding		STROKE	
RENAL FAILURE OR DIALYSIS		SEIZURES	
HEART DISEASE: (circle): angina, heart attack, congestive heart failure, angioplasty or stents, irregular beat, leaky or narrow valve		OTHER:	

**Past Surgical History: Please list all of your operations or procedures:**

DATE	OPERATION OR PROCEDURE	SURGEON

(please continue on the reverse side)

## NEW PATIENT HISTORY, PAGE 2

**Social History:** TOBACCO USE: Do you smoke cigarettes now? \_\_\_\_\_. Have you smoked in the past? \_\_\_\_\_. If quit, when? \_\_\_\_\_. How many packs per day? \_\_\_\_\_. How many years? \_\_\_\_\_  
 ALCOHOL USE: Do you drink alcohol now? \_\_\_\_\_. How much of what kind? \_\_\_\_\_  
 DRUG USE: Do you use drugs? \_\_\_\_\_. What kind and how often? \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_. MARITAL STATUS: \_\_\_\_\_  
 SPECIAL DIET: \_\_\_\_\_  
 NEXT OF KIN or FAMILY SUPPORT (include phone #) \_\_\_\_\_

**Family history:** Please indicate if there is any family history of: aneurysm, coronary heart disease, diabetes, renal failure, blood clots, amputation, strokes, or peripheral vascular disease.

RELATIVE	Alive? (yes or no)	If alive, write in any diseases	If deceased, write in cause of death
MOTHER			
FATHER			
SIBLINGS			
OTHER			

**Review of Systems:** Please check the box if any problem is significant to you.

GENERAL		Murmur		Abnormal vaginal blood	
Fever or chills		Ankle swelling			
Unexplained weight loss				MUSCULOSKELETAL	
		VASCULAR		Bone or joint pain	
EYES		Calf cramps with walking		Swollen joints	
Vision loss		Foot pain at night			
Glaucoma		Cool feet		ENDOCRINE	
		Blue feet		Heat/cold intolerance	
EARS, NOSE, THROAT		Ulcers on feet or legs		Excessive thirst	
Hearing loss		Varicose veins or clots			
Sinus problems				SKIN	
Cold or flu symptoms		GASTROINTESTINAL		Rash	
Hoarse or voice change		Abdominal pain		Itching	
		Nausea, vomiting		Jaundice	
RESPIRATORY		Heartburn, indigestion			
Wheezing		Trouble swallowing		NEUROLOGIC	
Cough		Loss of appetite		Headache	
Short of breath		Diarrhea, constipation		Numb / weak / paralysis	
Sleep apnea		Tarry or bloody stool		Seizures	
				Dizziness	
CARDIAC		GENITOURINARY			
Chest pain		Painful urination		PSYCHIATRIC	
Palpitations		Blood in urine		Depression	
Irregular heart beat		Slow or small stream		Anxiety	

REVIEWED AND VERIFIED BY: \_\_\_\_\_ NURSE \_\_\_\_\_ MD Date \_\_\_\_\_