Associates in Vascular Care
New Patient History Form

Patient Name:_____ Date of Birth:_____

Primary Physician: _____ Referring Physician: _____

Reason for Today's Visit:

- € Pain in Legs with walking
- € Arterial Disease
- € Vein Problems
- € Varicose Veins
- € Spider Veins
- € Carotid Artery
- € Abdominal Aortic Aneurysm (AAA) _____
- € Chronic Ulcers/ Wounds _____
- € Swelling Arms / Legs _____
- € Kidney Disease (Dialysis)
- € Other:_____

Description and Location of Symptoms: _____

_____

_____

_____

Wound History: (If you don't have a wound please see next section)

Where is your Wound? _____
What caused the Wound? _____
Has the wound been treated? _____
How Long? _____
How long has the wound been present? _____
Have you had similar wounds? _____

Medical History:

- € Heart Disease
- € Heart Attack
- € High Blood Press.
- € High Cholesterol
- € Diabetes
- € Stroke
- € Liver Disease
- € Irregular Heart Beat
- € Cancer (Type) _____
- € Blood Clot
- € Arthritis
- € Pacemaker
- € # of Pregnancies_____
- € COPD
- € Aneurysm
- € Hepatitis Type _____
- € Bleeding Disorder
- € Kidney Disease
- € Lung Disease
- € Other History: _____

Surgical History:

Surgery:	**Date / Year:**

Allergies / Medication Allergies: € None

Allergies:	Reactions:

Family History: (Identify family member: Mother, Father, Siblings, and Grandparents)

€ Heart Disease _____ € Aneurysm _____
€ High Blood Pressure _____ € Varicose Veins _____
€ Stroke _____ € Bleeding Disorder _____
€ Diabetes _____ € High Cholesterol _____
€ Cancer _____ € Other History _____

Other Symptoms:

€ Weight Loss € Legs Cramps € Fever € Headaches
€ Cataracts € Joint Pains € Glaucoma € Seizures
€ Blurry Vision € Back Pain/ Sciatica € Shortness of Breath € Depression
€ Chest Pain € Anxiety € Vomiting € Thyroid Problems
€ Nausea € Psychosis € Diarrhea € Bleeding Problems
€ Heartburn € Rashes € Urinary Symptoms € Phlebitis
€ Bloody Stools € Blood Clots € Leg Pains € Cold Hands/ Feet _____
€ Kidney Problems € Lupus € Other Symptoms: _____

Social History:

€ Married € Single € Divorced € Widow
€ Need Help with Daily Activities: YES or NO
€ Walk Alone € Wheelchair Dependent € Walker € Cane
€ Retired: YES or NO (If Answered No) € Occupation:_____
€ Tobacco Use: YES or NO (If Answered Yes)
Amount: _____ Length of Use: _____ Quit: When _____
€ Alcohol Use: YES or NO (If Answered Yes)
Amount: _____ Length of Use: _____ Quit: When _____