LAKE WASHINGTON VASCULAR

PATIENT LABEL HERE

PATIENT HEALTH HISTORY

Please fill in all the information as accurately as possible. *The information you provide will help create a complete or updated patient chart. All answers are confidential.*

Patient's Name (Last, First, Middle): _____ Date: _____

Reason for Visit: _____

Please list your current: Height: _____ and Weight: _____

Do you, or have you ever had any of the following medical problems (check all that apply):

Cardiovascular

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ Stent ☐ Angioplasty ☐ Heart Bypass Check
- ☐ Heart Attack, when: _____
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Pacemaker of Defibrillator
- ☐ Aneurysm, where: _____
- ☐ Peripheral Vascular Disease
- ☐ Blood Clot, where: _____
- ☐ Pulmonary Embolism
- ☐ Varicose Veins: ☐ Left ☐ Right
- ☐ Spider Veins: ☐ Left ☐ Right
- ☐ High Cholesterol
- ☐ Other: _____

Pulmonary

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea ☐ Using CPAP
- ☐ Other: _____

Neurological

- ☐ Stroke
- ☐ Transient Ischemic Attack/TIA (mini-stroke)
- ☐ Migraine Headaches
- ☐ Other: _____

Preferred Pharmacy

Please let us know where you would like us to send any medications that we prescribe

Name: _____

Location: _____

Phone No. _____

Fax No. _____

Gastrointestinal

- ☐ Acid Reflux (GERD)
- ☐ Ulcers
- ☐ Liver Disease/Hepatitis
- ☐ Hemorrhoids
- ☐ Other: _____

Skin

- ☐ Skin Ulcers, where: _____
- ☐ Dermatitis
- ☐ Other: _____

Genitourinary

- ☐ Kidney Failure
- ☐ Are you on dialysis, what type: ☐ Hemodialyis ☐ Peritoneal
- ☐ Kidney Stones
- ☐ Incontinence
- ☐ Enlarged Prostate
- ☐ Impotence/Erectile Dysfunction
- ☐ Other:

Endocrine/Other

- ☐ Cancer, type: _____
  Treatment: _____
- ☐ Diabetes, type: ☐ Type 1 ☐ Type 2
- ☐ Fibromyalgia
- ☐ Other: _____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other: _____

Musculoskeletal

- ☐ Back Problems
- ☐ Neck Problems
- ☐ Arthritis
- ☐ Gout
- ☐ Treatment for Chronic Pain
- ☐ Other: _____

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MEDICATION ALLERGIES ☐ No Allergies	
Medication Name	Reaction

MEDICATIONS (Prescription and Non-Prescription) ☐ No Medications		
Medication Name	**Dose**	Medication Instructions

SURGICAL HISTORY ☐ No Surgeries		
Date	**Description**	Hospital and Surgeon

SOCIAL HISTORY

Tobacco:

- ☐ Current Smoker
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Occasional Smoker

Type:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Chewing Tobacco

If you are a smoker, how long have you been smoking: _____

How many packs per day: _____

If you are a former smoker, when did you quit: _____

If you are still smoking, do you have plans to quit: _____

Living Situation:

- ☐ Alone
- ☐ Assisted Living
- ☐ Family
- ☐ Spouse/Significant Other, name: _____
- ☐ Other: _____

Occupation: _____

Alcohol:

- ☐ Never
- ☐ Occasionally
- ☐ Daily
- ☐ Weekly

How Many Drinks Per:

- ☐ Day: _____
- ☐ Week: _____

Do you use any recreational drugs:

- ☐ Yes
- ☐ No

If yes, please list: _____

Children:

How many: _____

Ages: _____

Currently Pregnant:

- ☐ Yes
- ☐ No

Currently Breastfeeding:

- ☐ Yes
- ☐ No

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FAMILY HISTORY (Check All That Apply)						
	Father	**Mother**	**Paternal Grandparents**	**Maternal Grandparents**	**Siblings**	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Blood Clots						
Varicose Veins						
Aneurysm						

Review of Systems

Are you CURRENTLY experiencing any of the following symptoms (check all that apply)

Constitutional Problems

- ☐ Unintentional Weight Gain/Loss
- ☐ Fever
- ☐ Other: _____

Cardiovascular

- ☐ Chest Pain/Angina
- ☐ Heart Palpitations
- ☐ Other: _____

Respiratory

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Other: _____

Gastrointestinal

- ☐ Pain w/ Eating
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Blood in Stool
- ☐ Jaundice (yellow skin/eyes)
- ☐ Other: _____

Genitourinary

- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Blood in Urine
- ☐ Difficulty Starting Urine Stream
- ☐ Other: _____

Musculoskeletal

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain, where: _____
- ☐ Muscle Pain, where: _____
- ☐ Other: _____

Skin

- ☐ Rash
- ☐ Itching
- ☐ Ulcers
- ☐ Wounds
- ☐ Other: _____

Vascular

Are you legs:

- ☐ Heavy
- ☐ Aching
- ☐ Swollen
- ☐ Throbbing
- ☐ Itching
- ☐ Other: _____

Neurological

- ☐ Sudden Change in Consciousness
- ☐ Transient Change in Speech
- ☐ Transient Weakness in Arm or Leg
- ☐ Sudden or Severe Headache
- ☐ Sudden Vision Change
- ☐ Other: _____

Patient Signature: _____ Date: _____

Patient Representative's Signature: _____ Date: _____

Relationship to Patient:

☐ Parent ☐ Legal Guardian* ☐ Medical Power of Attorney* ☐ Executor of Estate*

Please attach legal documentation if you are the Legal Guardian, Medical Power of Attorney, or Executor of Estate