WENTWORTH HEALTH PARTNERS

THE CARDIOVASCULAR GROUP

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VASCULAR SURGEONS

Name: _____DOB: ___/____/___ Age: ___Sex: ❑ M ❑ F Date: _____

	Medical History	Year	Have Now? Yes	Have Now? No	In Past? Yes	In Past? No	IMMEDIATE Family Medical History (who?)	Year	Yes	No
HEART DISEASE	Heart attack		❑	❑	❑	❑			❑	❑
	Congestive Heart Failure		❑	❑	❑	❑			❑	❑
	High blood pressure		❑	❑	❑	❑			❑	❑
	Angina		❑	❑	❑	❑			❑	❑
LUNG PROBLEMS	Asthma		❑	❑	❑	❑			❑	❑
	Bronchitis		❑	❑	❑	❑			❑	❑
	COPD		❑	❑	❑	❑			❑	❑
	Emphysema		❑	❑	❑	❑			❑	❑
	Pneumonia		❑	❑	❑	❑			❑	❑
GASTRO PROBLEMS	Ulcers		❑	❑	❑	❑			❑	❑
	Gallbladder disease		❑	❑	❑	❑			❑	❑
	Liver disease/cirrhosis		❑	❑	❑	❑			❑	❑
	Diverticulosis		❑	❑	❑	❑			❑	❑
	Hiatal hernia		❑	❑	❑	❑			❑	❑
BONE & JOINT	Arthritis		❑	❑	❑	❑			❑	❑
	Osteoporosis		❑	❑	❑	❑			❑	❑
	Gout		❑	❑	❑	❑			❑	❑
KIDNEY & URINARY	Kidney disease		❑	❑	❑	❑			❑	❑
	Frequent bladder or kidney infection		❑	❑	❑	❑			❑	❑
	Prostrate disease		❑	❑	❑	❑			❑	❑
	Urinary inconsistency		❑	❑	❑	❑			❑	❑
NERVOUS SYSTEM	Stroke		❑	❑	❑	❑			❑	❑
	Numbness Tingling (arms/legs)		❑	❑	❑	❑			❑	❑
	Dementia & Alzheimer's		❑	❑	❑	❑			❑	❑
	Parkinson's disease		❑	❑	❑	❑			❑	❑
	Epilepsy or seizures		❑	❑	❑	❑			❑	❑
GLAND	Thyroid disease		❑	❑	❑	❑			❑	❑
	Diabetes		❑	❑	❑	❑			❑	❑
OTHER HEALTH PROBLEMS	Significant Weight Loss or gain		❑	❑	❑	❑			❑	❑
	Anemia		❑	❑	❑	❑			❑	❑
	Hernia		❑	❑	❑	❑			❑	❑
	Thombois (blood clots)		❑	❑	❑	❑			❑	❑
	Depression		❑	❑	❑	❑			❑	❑
	Cancer of:		❑	❑	❑	❑			❑	❑

LIST SURGERIES (OPERATIONS OR HOSPITALIZATIONS)

Patient Name:_____

Date of Birth: _____

MARITAL STATUS / FAMILY / SOCIAL SUPPORT

Are you currently (check one)?

❑ Married ❑ Divorced or separated ❑ Living with significant other ❑ Single, never married ❑ Widowed

Do you have children? ❑ **Yes** / ❑ **No** If yes, how many _____ daughters, _____sons

With whom do you live? (Check one):

❑ Alone ❑ Spouse or Partner ❑ Child or other family member ❑ Others, not family ❑ Other: Specify:_____

SOCIAL HABITS

<table>
<tr><th>Smoking</th><th colspan="2">Drinking</th><th>Employment</th></tr>
<tr><td>Have you <u>ever</u> smoked?
❑ Yes / ❑ No</td><td colspan="2" rowspan="2">Do you drink any alcoholic beverages? (e.g., beer, wine or other alcohol such as vodka, whiskey, gin, rum, etc.)?
❑ Yes / ❑ No</td><td>Do you work?
❑ Yes / ❑ No</td></tr>
<tr><td>• If yes, how many packs per day do (did) you smoke?</td><td>If yes, where:</td></tr>
<tr><td>• How many years did/have you smoked?</td><td colspan="2"><u>How Often:</u></td><td rowspan="4"></td></tr>
<tr><td rowspan="3">• Did you quit, if yes, when?
_____</td><td>❑ Daily</td><td>❑ 4-6 times/week</td></tr>
<tr><td>❑ > one time/ week</td><td>❑ 1-3 times week</td></tr>
<tr><td>❑ Never</td><td></td></tr>
</table>

REVIEW OF SYSTEMS:

	Yes	No		Yes	No
Unexplained weight loss	❑	❑	Change in vision	❑	❑
Change in hearing	❑	❑	Trouble swallowing	❑	❑
Loss of balance	❑	❑	Shortness of breath	❑	❑
Decreased exercise tolerance	❑	❑	Chest pain	❑	❑
Pain between your shoulders	❑	❑	Neck pain	❑	❑
Change in bowel habits	❑	❑	Bloody stools	❑	❑
Frequent urination	❑	❑	Bloody urine	❑	❑
Do you bruise easily	❑	❑	Yellow skin	❑	❑
Unexplained rash	❑	❑	Trouble walking	❑	❑
Aching joints	❑	❑	Weakness in your extremities	❑	❑

DO YOU HAVE ANY ALLERGIES: ❑ Yes ❑ No

ALLERGY TO:	REACTION:

IS THERE ANYTHING ELSE WE SHOULD BE AWARE OF? ❑ Yes ❑ No

_____

_____

_____

_____

Prepared by (please print): _____

Relationship to Patient: _____

Signature: _____

Date: _____