

COASTAL VASCULAR & INTERVENTIONAL, PLLC

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Who recommended you to this office? _____

HISTORY OF PRESENT ILLNESS:

What are you being seen for today: _____

When did this begin: _____ Have you ever had this problem before: { } Yes { } No

Has any other physician seen you for this condition: { } Yes { } No Name: _

Family Physician: _____

MEDICAL HISTORY: Please check all that apply

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Murmurs |
| <input type="checkbox"/> Arthritis (Location) _____ | <input type="checkbox"/> Abnormal Rhythm | <input type="checkbox"/> Congestive Heart Failure | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hernia | | |
| <input type="checkbox"/> Blood Diseases { } Anemia { } Leukemia | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Blood Transfusion (when) _____ | <input type="checkbox"/> High Cholesterol | | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV Positive | | |
| <input type="checkbox"/> Cancer (Type) _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Cysts |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Latex Allergy | | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver Cirrhosis | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Parkinsonism | | |
| <input type="checkbox"/> Drug Addition | <input type="checkbox"/> Peptic Ulcers | | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Prostate - | <input type="checkbox"/> Enlarged | <input type="checkbox"/> Inflammation { } Cancer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psoriasis | | |
| <input type="checkbox"/> Fracture/Broken Bones (where) _____ | <input type="checkbox"/> Stroke | | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Disease | | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis | | |
| <input type="checkbox"/> Other _____ | | | |

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PAST PROCEDURE: Please check all that apply & enter year, complications & left or right _____

PROCEDURE (Year, Left or Right, Complications)	PROCEDURE (Year, Left or Right, Complications)
{ } Appendectomy _____	{ } Back PROCEDURE _____
{ } Arthroscopy _____	{ } Neck PROCEDURE _____
{ } Joint Replacement (Location): _____	{ } Kidney PROCEDURE _____
{ } Breast PROCEDURE _____	{ } Pacemaker _____
{ } Cataract PROCEDURE _____	{ } Hysterectomy _____
{ } Carpal Tunnel _____	{ } Prostate PROCEDURE _____
{ } Skin Cancer _____	{ } Cesarean Section _____
	{ } D & C _____
	{ } Gallbladder PROCEDURE _____
{ } Other: _____	{ } Heart Bypass _____
	{ } Heart Valve Replacement _____
	{ } Tonsillectomy _____

MEDICATIONS – Please list all medications you are presently taking. _____

Example : Medication **Synthroid** Mg. **.5** Dosage: **1** per day

Medication	Mg.	Dosage	Medication	Mg.	Dosage

SOCIAL HISTORY – Please check all that apply.

Drug Allergies: _____

Have you ever smoked tobacco: Yes No How much per day? _____ When did you quit? _____

Have you ever taken drugs not prescribed by a physician: Yes No What: _____

Are you currently taking any over the counter drugs? Yes No What: _____

Are you currently taking any herbal drugs? Yes No What: _____

Do you consume alcohol: Yes No How much: _____

Occupation: _____

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SYSTEM REVIEW: Please circle all that apply today

GENERAL:	Chills Weight loss	Sweats Weight gain	Anorexia	Fatigue
EYES:	Visual changes Discharge	Blurring Loss	Double vision Pain	Irritation Pain in sun
EAR NOSE THROAT:	Earache Post nasal drip	Ringing in ears Runny nose	Hearing loss Facial pressure	Sore throat Painful teeth
RESP:	Cough COPD	Shortness of breath Emphysema	Difficult breathing	Coughing blood
CARDIO/VASCULAR:	Chest pain Difficulty on Exercising	Palpitations PND	Syncope Edema	Tachycardia
GASTRO INTESTINAL:	Vomiting Diarrhea Abdominal pain	Heart Burn Constipation	Reflux Black stools	Anorexia Bloody stools
GENITAL/URINARY:	Painful Urination Nighttime Discharge	Frequency Urination Testicle pain	Hesitancy Bloody Urine	Urgency Sores
GYNOCOLOGY:	Discharge Sores	Odor Irregular menses	Pelvic pain	Painful coitus
MUSCULOSKELETAL:	Back pain Decreased ROM	Joint Pain Altered gait	Joint swelling	Muscle Pain
SKIN:	Rash Bruising Pinpoint red/purple spots	Itching Bleeding under skin Hardened skin due to swelling	Dryness Redness of skin	Ulcers
ENDOCRINE:	Heat/cold intolerance	Increase thirst	Increase hunger	Increase urination
NEUROLOGY:	Weakness Dizziness	Abnormal sensation Headache	Painful skin	Seizures Tremor
PSYCHOLOGY:	Depression Suicidal thoughts Loss of contact with reality	Anxiety Agitation	Panic Unstable mood	Memory loss Insomnia
HEME/LYMPH/ID:	Abnormal bleeding Transfusion	Bruising HIV exposure	Swollen glands	Anemia

Sexually transmitted diseases: _____

OTHER: _____

FAMILY HISTORY:

Please list any blood relative and their relationship to you that have had any of the following (paternal or maternal):

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Rheumatoid Arthritis _____

Other _____

Medical History **Patient Name:** _____ **Date of Birth:** _____