

# 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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## PATIENT MEDICAL HISTORY

**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:** \_\_\_\_\_