Northside VASCULAR SURGERY

NORTHSIDE HOSPITAL HEART & VASCULAR INSTITUTE

English - Spanish

PATIENT MEDICAL HISTORY

Today's Date: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Self Medical History:

Please indicate whether YOU have had any of the medical illnesses listed below (check all that apply).

Sensory Defects

- Loss of Hearing or Deaf ☐ Yes
- Loss of Vision or Blind ☐ Yes

Respiratory (Lung or Breathing Problems)

- Asthma / Wheezing ☐ Yes
- Emphysema / COPD ☐ Yes
- Sleep Apnea ☐ Yes

Cardiac (Heart Problems)

- Fast Heart Rate Requiring Therapy ☐ Yes
- Heart Attack / Angioplasty / CABG ☐ Yes
- Heart Failure ☐ Yes
- Heart Murmur ☐ Yes
- High Blood Pressure ☐ Yes
- High Cholesterol ☐ Yes

Vascular (Circulation Problems)

- Aneurysm ☐ Yes
- Peripheral Artery Disease ☐ Yes
- Varicose veins ☐ Yes
- Wounds or Sores ☐ Yes

Gastrointestinal (GI or Abdominal Problems)

- Gallbladder Problems ☐ Yes
- Hepatitis ☐ Yes
- Liver Disease ☐ Yes
- Ulcers ☐ Yes

Renal (Kidney Problems)

- Kidney Failure ☐ Yes
- Kidney Disease ☐ Yes
- Kidney Stones ☐ Yes

Immunologic / Infectious Disease

- AIDS ☐ Yes
- HIV ☐ Yes
- Auto-Immune (e.g. Lupus) ☐ Yes

Endocrine

- Diabetes ☐ Yes
- Low Blood Sugar ☐ Yes
- Thyroid Problems ☐ Yes

Musculoskeletal (Bone, Joint, or Muscle Problems)

- Arthritis ☐ Yes
- Osteoporosis ☐ Yes

Neurological (Brain or Nerve Problems)

- Headaches / Migraines ☐ Yes
- Parkinson's / Tremor ☐ Yes
- Seizures ☐ Yes
- Stroke ☐ Yes
- TIA ☐ Yes

Mental Health

- Alzheimer's / Dementia ☐ Yes
- Anxiety ☐ Yes
- Depression ☐ Yes
- Mental Illness ☐ Yes

Hematologic (Blood Problems)

- Anemia ☐ Yes
- Bleeding Disorder ☐ Yes
- Clotting Problems ☐ Yes

Oncologic (Cancer)

- If yes, what type? ______________________________
- Chemotherapy ☐ Yes
- Radiation Therapy ☐ Yes

Other Medical Illnesses (please list)

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Today's Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

Family Medical History:

Please indicate whether any of your **BLOOD RELATIVES** have any of the medical illnesses listed below. (List relationship)

- ☐ Aneurysm ____________
- ☐ Stroke ____________
- ☐ Diabetes ____________
- ☐ Heart Disease ____________
- ☐ High Blood Pressure ____________
- ☐ Artery Blockage in Legs ____________
- ☐ Kidney Problems ____________
- ☐ DVT ____________
- ☐ Varicose Veins ____________
- ☐ Bleeding Disorders ____________

Previous surgeries or hospitalizations:

Reason	Date	Hospital Name	Any Complications

Social History

Do you currently smoke? .... ☐ Yes ☐ No

How long have you been smoking? _______ months _______ yrs

How many cigarettes per day? ____________

If you don't currently smoke, have you ever smoked? .... ☐ Yes ☐ No

Do you use Smokeless Tobacco/Vapors? .... ☐ Yes ☐ No

How often? ____________

Do you drink Alcohol? .... ☐ Yes ☐ No

How often? ____________

Any history of drug use? .... ☐ Yes ☐ No

Do you Work? .... ☐ Yes ☐ No

What is your occupation? ____________________

Retired? ____________