Health History – UW Medicine Regional Vascular Center at NW

Name: Last _____ **First** _____ **MI** _____ **Date:** _____

Birthdate: _____ **Gender:** _____ **E-Mail :** _____

REASON FOR VISIT: _____ **Preferred Pharmacy:** _____

Referring Provider: _____ **Specialty:** _____

Allergies: ☐ No Allergies	**Medication or Substance**	**Reaction**

Current Medications:	**Label - Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Social History

☐ Single ☐ Married ☐ Domestic Partner (Spouse/Partner Name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Specialty Medical History

Please check box for those conditions you have now or have ever had.

- ☐ Acute DVT
- ☐ Aortic Aneurysm
- ☐ Aortic Dissection
- ☐ A-V Malformation
- ☐ Cerebrovascular Disease
- ☐ Chronic DVT
- ☐ Deep Vein Thrombosis
- ☐ Hemodialysis Access
- ☐ Lymphedema
- ☐ Peripheral Vascular Disease
- ☐ Renal Artery Stenosis
- ☐ Renovascular Disease
- ☐ Thrombophlebitis
- ☐ Thrombosis
- ☐ Thrombosis, Mesenteric Vein
- ☐ Thrombosis, Pelvic Vein
- ☐ Ulcers

PLACE PATIENT LABEL HERE

General Medical History

Please check box for those conditions you have now or have ever had.

- ☐ No Past Medical History
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Transfusion
- ☐ Cancer (Type:_____)
- ☐ Other (Please list):
- ☐ CHF
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ GYN (Type:_____)
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis (Type:_____)
- ☐ HIV
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lipid/Cholesterol
- ☐ Lung Disease
- ☐ Musculoskeletal
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ PPD
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

Surgical History

Please check box for any surgery you have had. Indicate Year (YYYY).

- ☐ No Past Surgical History
- ☐ Amputation (____)
- ☐ Aneurysm Repair (____)
- ☐ Appendectomy (____)
- ☐ Arterial Bypass (____)
- ☐ Other (Please list):
- ☐ CABG (____)
- ☐ Carotid Endarterectomy (____)
- ☐ Carotid Stent Replacement (____)
- ☐ Cholecystectomy (____)
- ☐ Coronary Angioplasty (____)
- ☐ Coronary Endarterectomy (____)
- ☐ Dialysis (____)
- ☐ Fistula/ Graft (____)
- ☐ Hysterectomy (____)
- ☐ Leg Artery Stent Placement (____)
- ☐ Renal Artery Stent (____)
- ☐ Splenectomy(____)
- ☐ Transplant (____)
- ☐ Vein Surgery (____)

History of Hospitalizations (Include surgeries noted above).

If you required hospitalization for an illness other than the disease you are being seen for today, please describe below.

Month/Year	Illness	Month/Year	Illness

Family History – Check all that apply.

Relationship	First Name	Status (circle)	Alcohol/Drug Abuse	Amputations	Aneurysm	Arthritis	Asthma	Birth Defects	Bleeding Disorder	Cancer **	Clotting Disorder	COPD	Depression	Diabetes	Deep Vein Thrombosis	Drug Abuse	Early Sudden Death	Hearing Loss	Heart Attack	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Miscarriages	Stroke	Varicose Veins	Vascular Malformation	Vision Loss
Mother		alive deceased																										
Father		alive deceased																										
Sister		alive deceased																										
Brother		alive deceased																										
Maternal Grandmother		alive deceased																										
Maternal Grandfather		alive deceased																										
Paternal Grandmother		alive deceased																										
Paternal Grandfather		alive deceased																										

****Type of Cancer or Disease:**

Review of Systems (Current Symptoms) – Please check only if these are bothering you at this time

PLACE PATIENT LABEL HERE

Gastrointestinal:

- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/Indigestion
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Vomiting Blood
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Abdominal Swelling
- ☐ Trouble Swallowing
- ☐ Rectal Bleeding
- ☐ Other (Please list):

Constitutional:

- ☐ Fevers
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

Head/Eyes:

- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Poor Vision
- ☐ Color Blindness

Ears/ Nose/ Mouth/ Throat:

- ☐ Hearing Loss
- ☐ Chronic Sinus Congestion
- ☐ Heavy Snoring
- ☐ Bad Teeth

Respiratory (Lungs):

- ☐ Cough
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema (COPD)

Muscle/ Bones:

- ☐ Chronic Pain
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Cramping
- ☐ Bone Pain
- ☐ Joint Pain

Skin:

- ☐ Rash
- ☐ Jaundice
- ☐ Itching
- ☐ Psoriasis

Neurological:

- ☐ Headaches
- ☐ Seizures
- ☐ Confusion
- ☐ Tremor (shaking)

Vascular:

- ☐ Blood Clots
- ☐ Varicose Veins

Psychosocial:

- ☐ Anxiety / Nerves
- ☐ Abusive Relationship
- ☐ Sexual Difficulties
- ☐ Insomnia
- ☐ Alcohol Use
- ☐ Depression
- ☐ Feeling Worthless
- ☐ Want to Hurt Yourself
- ☐ Want to Hurt Others
- ☐ Drug Use

Endocrine:

- ☐ Hot Flashes
- ☐ Intolerance to Heat
- ☐ Excessive Thirst
- ☐ Intolerance to Cold

Blood/ Lymph:

- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Easy Bleeding