



DIVISION OF

VASCULAR AND ENDOVASCULAR SURGERY

NEW PATIENT HISTORY FORM

Reason for visit:

Date of visit:

Referring Physician: \_\_\_\_\_
Address: \_\_\_\_\_

Patient Medical History

Previous hospitalizations/Surgeries/Serious Injuries

Current Prescription and Over the Counter Medications

Any Known Drug Allergies?

Type of Reaction

Date of last Immunizations: Tetnus \_\_\_\_\_ Hep B Series \_\_\_\_\_
Flu Shot \_\_\_\_\_ PPD (TB Test) \_\_\_\_\_

Patient Social History

(Please circle)

Marital Status: Single Male Married Female Separated Divorced Widowed
Use of alcohol: Never Rarely Moderate Daily
Use of tobacco: Never Previously, but quit \_\_\_\_\_ Currently, packs/day \_\_\_\_\_
Use of drugs: Never Type/Frequency \_\_\_\_\_

Would you like information that would help you stop any alcohol, tobacco, or drug use? YES / NO

Occupation: \_\_\_\_\_

Family Medical History

Table with 3 columns: Age, Any Diseases/Conditions Past/Present, If Deceased, Cause of death. Rows include Father, Mother, Siblings, Children.

Review of Systems

(please circle any of the listed symptoms that are current or past problems for you)

- Constitutional: Fever Chills Weight loss or gain Fatigue
Eyes: Double vision Blurry vision Need for glasses Glaucoma Injury or surgery
Ear, Nose, Throat: Sinusitis Hearing Loss Ringing in ears Sores Voice Change Swelling
Cardiovascular: Heart attack Chest pain High blood pressure Palpatations Leg Swelling
Respiratory: Shortness of breath Asthma Cough Spitting up blood Wheezing
Gastrointestinal: Loss of appetite Nausea Vomiting Abnormal bowel movements Pain
Genitourinary: Frequent or painful urination Incontinence Infections Irregular menses
Musculoskeletal: Joint pain or stiffness Weakness Injury or surgery Swelling Spasm
Skin/Breast: Rashes Ulcers Nail changes Breast pain or lump or discharge
Neurological: Stroke or TIA Headaches Dizziness Seizures Loss of balance
Psychological: Memory loss Depression Insomnia Nervousness
Endocrine: Diabetes Thyroid problem Excessive thirst or urination
Hematologic: Bleeding or bruising tendency Phlebitis DVT Transfusion

Other Pertinent ROS

Physician's Signature: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_