



HISTORY FORM

Last Name: _____ First Name: _____ MI: _____
 Who sent you to us? _____ Who is your primary doctor? _____
 Why were you sent to us? _____

VASCULAR INFORMATION

	Patient	Family
Have you ever had a "mini-stroke?"	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had a stroke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever been told you had an aneurysm? (Bubbling out of an artery)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have numbness in your feet?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have sores or ulcers on your feet or ankles?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have swelling of your legs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have varicose veins?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you had blood clots in your legs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you been told you have a blood disorders?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have difficulty walking?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
How far can you walk?		
<input type="checkbox"/> Around the house	<input type="checkbox"/> ½ Block	<input type="checkbox"/> 1 Block
<input type="checkbox"/> 2 Blocks	<input type="checkbox"/> ½ mile or more	
Do you walk	<input type="checkbox"/> without help	<input type="checkbox"/> use a cane
<input type="checkbox"/> use a wheelchair?	<input type="checkbox"/> use crutches	<input type="checkbox"/> use a walker

Are your parents still alive? No Yes if no, what did they die of? _____

GENERAL INFORMATION

Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes

GASTROINTESTINAL

Loss of appetite No Yes
 Change in bowel habit No Yes
 Abdominal pain or hernia No Yes
 Stomach ulcers No Yes
 Kidney or bladder problems No Yes

EYES

Blurred or double vision No Yes
 Glaucoma No Yes
 Blindness (temp/perm) No Yes

RESPIRATORY

Chronic or frequent coughing No Yes
 Shortness of breath No Yes

EARS/NOSE/THROAT

Chronic sinus problem or rhinitis No Yes
 Nosebleeds No Yes
 Sore throat No Yes
 Swollen glands in neck No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes

CARDIAC

Ever have heart failure No Yes
 Ever have heart attack No Yes
 Palpitations No Yes
 Shortness of breath while laying flat No Yes

PSYCHIATRIC

Nervousness No Yes
 Depression No Yes

ENDOCRINE

Thyroid Disease No Yes
Diabetes No Yes
Heat or cold intolerance No Yes
High blood pressure No Yes

MUSCULOSKELETAL

Arthritis No Yes
Back Pain No Yes
Cold extremities No Yes

PERSONAL HISTORY AND HABITS:

Tobacco use: Present no yes // Past: no yes Date Stopped _____
Alcohol-use: Present no yes // Past: no yes

ALLERGIES:

Please describe reactions

Food no yes _____
Penicillin no yes _____
Sulfa no yes _____
Iodine no yes _____
Codeine no yes _____
Tape no yes _____
Other no yes _____

OPERATIONS AND HOSPITALIZATION (Please list each with approximate date and hospital)

PHYSICIANS WHO ARE CURRENTLY TREATING YOU:

NAME: _____ phone _____
_____ phone _____
_____ phone _____

MEDICATIONS:

Medication	Amount	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LOCAL PHARMACY

TELEPHONE # _____

ADDRESS: _____
