Southern California Vascular Associates

Patient Name: ___________________________

Date of Visit: ________/_______/___________

Date of Birth: _______/______/__________

Reason for Visit Today: ____________________

Referring Physician: __________________

Primary Care Physician: ____________________

PAST MEDICAL HISTORY

CARDIOVASCULAR	
Congestive Heart Failure	◻
Deep Vein Thrombosis	◻
Heart Attack	◻
Heart Murmur	◻
High Blood Pressure	◻
High Cholesterol	◻
Irregular Heartbeat (Atrial Fibrillation)	◻

PULMONARY	
Asthma	◻
Chronic Obstructive Pulmonary Disease	◻
Emphysema	◻
Pneumonia	◻
Pulmonary Embolism	◻

GASTROINTESTINAL	
Cirrhosis	◻
Gastric Ulcer	◻
Gastroesophageal Reflux Disease	◻
Hepatitis	◻

ENDOCRINE	
Diabetes, Type I (Juvenile Onset)	◻
Diabetes, Type II (Adult Onset)	◻
Thyroid Disorder: Type: _____________	◻

MUSCULOSKELETAL	
Osteoarthritis	◻
Osteoporosis	◻
Low back pain	◻

NEUROLOGICAL	
Alzheimer’s Disease	◻
Cerebral Aneurysm	◻
Peripheral Neuropathy	◻
Seizure Disorder	◻
Stroke	◻
TIA	◻

KIDNEY	
Kidney Stones	◻
Prostate Enlargement	◻
Renal Failure (see page 3)	◻
Renal Insufficiency	◻

HEMATOLOGY/ONCOLOGY	
Anemia	◻
Bleeding Disorder	◻
Cancer (Type: ______________________)	◻

OTHER MEDICAL HISTORY	

ANESTHESIA

Have you ever had a reaction to anesthesia?

Yes ◻ No ◻

Please Describe: ____

____

PAST SURGICAL HISTORY: *(Please list all previous surgeries)*

	Date of Surgery	Procedure Performed	Surgeon’s Name
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

MEDICATION & SUPPLEMENT LIST

If additional space is required, please attach your medication list to this form.

Medications	Dosage	Times Taken Per Day	Date Started	Date Stopped

DRUG ALLERGIES AND REACTIONS:

Drug Name	Allergic Reaction

Are you allergic to latex? Circle One: YES NO

FAMILY MEDICAL HISTORY

(Please list any medical conditions in your family)

Relationship to Patient	Living/Deceased	Age	Medical Conditions
Mother			
Father			
Grandmother			
Grandfather			
Brother			
Sister			

SOCIAL HISTORY

(Have you ever used the following?)

Tobacco Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Alcohol Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Recreational Drug Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Regular Exercise: Circle one: YES NO How Often? ______________________________

DIALYSIS INFORMATION: **(If applicable)**

Type: Circle One: HEMO-DIALYSIS (HD) PERITONEAL (PD)

Days: Circle: Mon Tue Wed Thu Fri Sat

Dialysis Center: ____________________ Address: ____

City: __________________________ State: _________________________ Zip: ____________

Telephone Number: __________________________ Fax Number: __________________________

Nephrologist: ______________________________

*****Please fill out the next section if you are being seen for varicose veins or any other venous problem. ********

CURRENT VENOUS HISTORY

SYMPTOMS (Please check all that apply)

Left	Right		Left	Right	
☐	☐	Aching or Pain	☐	☐	Throbbing
☐	☐	Leg Cramps	☐	☐	Itching/Burning
☐	☐	Swelling	☐	☐	Heaviness
☐	☐	Tiredness/Fatigue	☐	☐	Restless Legs

Please indicate the duration of the above symptoms:

☐ 1-3 Months ☐ 4-6 Months ☐ 6-12 Months ☐ >12 Months

Are your daily activities impaired by the above symptoms? Yes No

Do you wear support hose or compression stockings? Yes No

Does standing aggravate your symptoms? Yes No

What helps to relieve your symptoms? ____

WOMEN: Do your symptoms increase before/during menstruation? Yes No
Are you pregnant or actively trying to become pregnant? Yes No
Are you breastfeeding? Yes No

Number of pregnancies ________

Number of Deliveries ________

VENOUS MEDICAL/SURGICAL HISTORY

History of:

☐ Vein Surgery If yes, year? ____ and MD name _________

☐ Vein Injections If yes, year? ____ and MD name _________

☐ Laser or RFA Treatment If yes, year? ____ and MD name _________

☐ Deep Vein Blood Clots If yes, year? ____

☐ Superficial Phlebitis If yes, year? ____

☐ Leg Ulcers Have they ever healed with wound care? ________

☐ Skin Discoloration Yes No

☐ Other Vein Treatment ____

REVIEW OF SYSTEMS (ROS):

PLEASE CIRCLE "Y" IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL		
Weight Gain	Y	N
Weight Loss	Y	N
Fatigue	Y	N
Weakness	Y	N
Fever	Y	N
Chills	Y	N
Night Sweats	Y	N
Other _______________		

SKIN		
Skin Changes	Y	N
Hair Changes	Y	N
Nail Changes	Y	N
Other _______________		

HEENT		
Headaches	Y	N
Vision Changes	Y	N
Acute Vision Loss	Y	N
Hoarseness	Y	N
Neck Pain	Y	N
Hearing Loss	Y	N
Other _______________		

CARVIOVASCULAR		
Chest Pain	Y	N
Palpitations	Y	N
Shortness Of Breath	Y	N
Difficulty Breathing Lying Flat	Y	N
Difficulty Breathing At Night	Y	N
Other _______________		

RESPIRATORY		
Wheezing	Y	N
Cough	Y	N
Bloody Sputum	Y	N
Other ______________		

GASTROINTESTINAL		
Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
History Of Ulcers	Y	N
Blood in Stool	Y	N
Other _______________		

GENITOURINARY		
Difficulty With Urination	Y	N
Blood In Urine	Y	N
Frequent Night Urination	Y	N
Pain With Urination	Y	N
Other ________________		

MUSCULOSKELETAL		
Muscle Weakness	Y	N
Muscle Pain	Y	N
Decreased Range Of Motion	Y	N
Swelling	Y	N
Gout	Y	N
Joint Pain/Stiffness	Y	N
Other ______________		

NEUROLOGICAL		
Sudden Blindness In One Eye	Y	N
Drooping Of The Face	Y	N
Difficulty With Speech	Y	N
Weakness/Paralysis Of Extremities	Y	N
Fainting/Blackouts	Y	N
Other _______________	Y	N

VASCULAR		
Pain In Legs With Walking	Y	N
How Far Can You Walk Without Pain ___________ Blocks		
Non-Healing Wounds	Y	N
Other _______________	Y	N

OTHER
____
____

Reviewed and discussed with patient.

Physician Signature:____ Date Reviewed: ______________________________