# Medical and Social History

**Patient Name** ___________________________________________  **Date** __/__/____

**Chief Complaint**
What is the main reason for your visit today? ______________________________________

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**Heart and Blood Pressure**
*If YES, please specify...*
- High Blood Pressure
- Angina Pectoris
- Heart Attacks  How many? ___  When? _________
- Heart Failure
- Previous Coronary Stenting/Ballooning
- Heart Valve Problems
- Previous Heart Valve Operations  When? _________
- Other Heart Problems  Specify: _________

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**Vascular Problems**
*If YES, please specify...*
- Previous Stroke (Major or Minor)
- Previous Carotid Surgery (Neck)  When? _________
- Pain in Legs while walking
- Non-healing Wounds on your Legs
- Previous Vascular Surgery  When? _________
- Aortic Aneurysm
- Previous Aneurysm Surgery  When? _________
- Previous Deep Vein Thrombosis (Blood Clot) When? _________

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**Lung Problems**
*If YES, please specify...*
- Asthma
- Emphysema
- Chronic Bronchitis/Pneumonia
- Lung Surgery or Intervention
- Other Lung Problems  Specify: _________
- Pulmonary Embolus

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Dose:

Allergies
What medications or substances are you allergic to? Please describe type(s) of reaction:

Reaction:

Past Surgical History
What surgical procedures did you have? Name all procedures, and if possible, the dates:

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<th>Procedures</th>
<th>Date</th>
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General Anesthesia
Have you ever had procedures under general anesthesia?  Yes  No
If Yes, did you have any adverse effects?  Yes  No
Please specify...

Family History

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<th>Alive</th>
<th>Deceased</th>
<th>Age at time of Death</th>
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Diabetes/Thyroid
If Yes, please specify...
- Diabetes Treated by __ Insulin __ Pills __ Diet
- Do you suffer from any complications?
  Which ones? ________________________
- Hyperthyroidism __ Hypothyroidism
- Other Endocrine conditions? ______
  Specify ________________________

High Cholesterol
If Yes, please specify...
- Treated by pills __ Treated by Diet
- Is this a common problem in your family?

Gastrointestinal
If Yes, please specify...
- Liver Disease
- Gastric Ulcers
- Rectal Bleeding or Black Stools
- Other Gastrointestinal problems ______
  Specify ________________________

Kidney
If Yes, please specify...
- Renal (kidney) failure __ How long? ______
- Do you require dialysis? __ How long? ______
- Do you have an intravenous Catheter for Dialysis? __
- What are the days you require Dialysis? ______
- Do you have a Peritoneal Catheter for Dialysis? __
- Other Renal (Kidney) Disease? Specify? ______

Other
If Yes, please specify...
- Were you diagnosed to have Cancer? Specify? ______

Habits
Do you use tobacco? __ Yes __ No
If Yes, please specify... __________________
  Amount per day _______ How many years ______

Do you drink Alcohol? __ Yes __ No
If Yes, please specify... __________________
  Amount per day _______ How many years ______

Prescribed Medications
What medications are you currently taking? Name pills, patches, and all other forms:
  Dose: __________________
  Dose: __________________
  Dose: __________________