CHEYENNE VASCULAR

# MEDICAL AND SOCIAL HISTORY

PATIENT NAME ______________________________ DATE ___/___/___

**CHIEF COMPLAINT**
What is the main reason for your visit today? ______________________________
______________________________________________________________

Do you suffer from any of the following?

**Heart and Blood Pressure** If YES, please specify...

- __ High Blood Pressure
- __ Angina Pectoris
- __ Heart Attacks How many? ___ When? ___________
- __ Heart Failure
- __ Previous Cornary Stenting/Ballooning
- __ Heart Valve Problems
- __ Previous Heart Valve Operations When? ___________
- __ Other Heart Problems Specify ___________

**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 ? ___________

**Lung Problems** If YES, please specify...

- __ Asthma
- __ Emphysema
- __ Chronic Bronchitis/Pneumonia
- __ Lung Surgery or Intervention
- __ Other Lung Problems Specify? ___________
- __ Pulmonary Embolis

______________________________________________ Dose: ____________________

## Allergies

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

______________________________ Reaction: ______________________________
______________________________ Reaction: ______________________________
______________________________ Reaction: ______________________________

## Past Surgical History

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

Procedures ______________________________ Date ___/___/___
______________________________ Date ___/___/___
______________________________ Date ___/___/___
______________________________ Date ___/___/___
______________________________ Date ___/___/___
______________________________ Date ___/___/___

## 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

| | | | | |
|---|---|---|---|---|
| Mother | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Father | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Brother 1 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Brother 2 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Brother 3 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Brother 4 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Brother 5 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 1 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 2 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 3 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 4 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 5 | __Alive | __Deceased | ____Age at time of Death | Cause of death________ |
| Sister 6 | __Alive | __Deceased | ____Age at time of Death | Cause of Death________ |

**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: ____________
____________________ Dose: ____________