

MOUNTAIN MEDICAL VASCULAR SPECIALISTS

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____

NAME: _____ AGE: _____ DOB: _____

GENDER: ___ Male ___ Female MARITAL STATUS: S M D W
PRIMARY CARE MD: _____ REF. MD _____

REASON FOR VISIT: _____

ALLERGIES: (list all of your allergies and describe the allergic reaction)

_____ **Any allergic reaction to:**
Iodine or X-ray contact dye ___ No ___ Yes
Latex or Rubber ___ No ___ Yes

MEDICATIONS: (please include dosage)

REVIEW OF SYSTEMS: (Check any of the problems you have)

YES NO

GENERAL:

- ___ ___ Recent weight change
- ___ ___ Fever
- ___ ___ Chills
- ___ ___ Night sweats

HEENT: (counts as 2 systems)

- ___ ___ Headache
- ___ ___ Blurry vision
- ___ ___ Loss of vision in one eye (at any time)
- ___ ___ Cataracts
- ___ ___ Glaucoma
- ___ ___ Macular Degeneration
- ___ ___ Hearing loss
- ___ ___ Hayfever
- ___ ___ Nose bleeds
- ___ ___ Dentures
- ___ ___ Retinopathy

RESPIRATORY:

- ___ ___ Asthma
- ___ ___ COPD
- ___ ___ Pneumonia
- ___ ___ Frequent cough
- ___ ___ Shortness of breath
- ___ ___ Shortness of breath at night

YES NO

GASTROINTESTINAL:

- ___ ___ Nausea
- ___ ___ Vomiting
- ___ ___ Abdomen pain
- ___ ___ Diarrhea
- ___ ___ Constipation
- ___ ___ Stomach ulcer
- ___ ___ Hemorrhoids
- ___ ___ Blood in stools
- ___ ___ Black stools
- ___ ___ Heart burn
- ___ ___ Trouble swallowing

URINARY:

- ___ ___ Blood in urine
- ___ ___ Prostate History
- ___ ___ Kidney Stones
- ___ ___ Kidney Failure
- ___ ___ Creatinine Problems

MUSCULOSKELETAL:

- ___ ___ General Weakness
- ___ ___ Arthritis
- ___ ___ Gout
- ___ ___ Paralysis
- ___ ___ Contractures
- ___ ___ Fibromyalgia

YES NO
CARDIOVASCULAR:
 ___ ___ Pacemaker /Date placed _____
 ___ ___ Congestive heart failure
 ___ ___ Exertional chest pain
 ___ ___ Heart Murmur
 ___ ___ Rapid/irregular heart beat
 ___ ___ High blood pressure
 ___ ___ Heart attack
 ___ ___ Rheumatic fever
 ___ ___ Phlebitis
 ___ ___ Varicose veins
 ___ ___ Ankle swelling
 ___ ___ Ulcer on extremities
 ___ ___ Blood Clots
 ___ ___ Any unhealed sore or abrasion
 ___ ___ Intermittent claudication (pain in calves)

YES NO
NEUROLOGICAL:
 ___ ___ Stroke
 ___ ___ Poor Memory
 ___ ___ Seizures
 ___ ___ Dizziness
 ___ ___ Tingling
ENDOCRINE:
 ___ ___ Excessive Dry Skin
 ___ ___ Cold/heat intolerance
 ___ ___ Thyroid problems
 ___ ___ Excessive Sweating
 ___ ___ Excessive thirst
 ___ ___ Cold/heat intolerance
 ___ ___ Diabetes Mellitus

PSYCHOLOGICAL:
 ___ ___ Depression
 ___ ___ Anxiety/ Panic Disorder
 ___ ___ Nervousness

I have reviewed all 11 ROS and it is located in the patient's permanent record _____
MD INT.

PREVIOUS SURGERY:

PAST MEDICAL PROBLEMS:

FAMILY HISTORY: (Relation to family members with the following)

Stroke	Yes	No	_____
High Cholesterol	Yes	No	_____
Cancer	Yes	No	_____
Heart Disease	Yes	No	_____
Blood Clots	Yes	No	_____
Bleeding Disorder	Yes	No	_____
Diabetes	Yes	No	_____
High Blood Pressure	Yes	No	_____
Abdominal Aortic Aneurysm	Yes	No	_____

SOCIAL HISTORY: (Answer the following)
 Do you or have you ever smoked? Yes No
 If so, how long and quantity? _____ Date stopped? _____
 Do you drink alcohol? Yes No
 If so, how often? _____
 Do you use recreational drugs? Yes No