 Peachtree Vascular Specialists, P.C. **HISTORY AND PHYSICAL**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today's Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Reason for Visit** | **Duration** |
| Varicose Veins/Spider Veins   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Carotid Blockage   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Stroke   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Aortic Aneurysm   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Leg Pains   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Leg Swelling   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Ulcer (Unhealing Wounds)   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| DVT (Blood Clots)   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Dialysis Problems   [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Heavy Prolonged Periods  [ ]    | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Pain/Pressure Between Hip Bones or in Back of Legs    [ ]  | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Pain During Sexual Intercourse    [ ]  | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |
| Other    [ ]  | Days [   ]   Weeks [   ]   Months [  ]   Years [  ]    |

**DRUGS AND MEDICATION:**  List all medications you take, including dosage and how often:

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage (Amount)** | **Frequency (How often)** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |

**\*\*Do you have any drug allergies? [ ] Yes   [ ] No**

**\*\*If so what drug(s) and type of reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*Do you have any Anesthesia Complications? [ ] Yes  [ ]  No**

**\*\*What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGERIES, HOSPITALIZATIONS & SERIOUS ILLNESSES:** List all previous operations, hospital visits & serious illness with reason approximate dates:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Past Surgeries** | **Yes** | **No** | **Past Surgeries** | **Yes** | **No** |
| Heart Bypass    | [ ]    | [ ]    | Gall Bladder    | [ ]    | [ ]    |
| Arterial Bypass    |  [ ]    | [ ]    | Appendix    | [ ]    | [ ]    |
| Vein Surgeries  | [ ]    | [ ]    | Hysterectomy    | [ ]    | [ ]    |
| AV Fistula Access     | [ ]    | [ ]    | C-Section    | [ ]    | [ ]    |
| AV Graft Access     | [ ]    | [ ]    | Tubal Ligation    | [ ]    | [ ]    |
| Stent Placement    | [ ]    | [ ]    | Hernia Repair    | [ ]    | [ ]    |
| Permacath Placement    | [ ]    | [ ]    | Hand Surgery    | [ ]    | [ ]    |
| Amputation    | [ ]    | [ ]    | Arm/Shoulder   | [ ]    | [ ]    |
| Carotid Endarterectomy    | [ ]    | [ ]    | Leg Surgery    | [ ]    | [ ]    |
| Arterial Surgery | [ ]    | [ ]    | Breast Surgery    | [ ]    | [ ]    |
| Aortic Abdominal Aneurysm Repair    | [ ]    | [ ]    | Other    | [ ]    | [ ]    |
| Other |  [ ]    | [ ]    | Other |  [ ]    | [ ]    |

**MEDICAL HISTORY & PROBLEMS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Problems** | **Yes** | **No** | **Medical Problems** | **Yes** | **No** |
| Aneurysm  | [ ]  | [ ]  | Stroke  | [ ]  | [ ]  |
| Anemia  |  [ ]   | [ ]  | Cancer  |  [ ]   | [ ]  |
| Blood Clot (DVT)  | [ ]  | [ ]  | Diabetes  | [ ]  | [ ]  |
| Carotid Disease   | [ ]  | [ ]  | Gastroesophageal Reflux Disease  | [ ]  | [ ]  |
| Peripheral Arterial Disease  | [ ]  | [ ]  | Thyroid Disease  | [ ]  | [ ]  |
| Varicose Veins   | [ ]  | [ ]  | Dialysis    | [ ]  | [ ]  |
| Venous Ulcers  | [ ]  | [ ]  | When?                                Where?  |  |  |
| Congestive Heart Failure   | [ ]  | [ ]  | Kidney Failure  | [ ]  | [ ]  |
| Heart Attack   | [ ]  | [ ]  | Liver Disease  | [ ]  | [ ]  |
| Irregular Heart Beat  | [ ]  | [ ]  | COPD  | [ ]  | [ ]  |
| Hypertension   | [ ]  | [ ]  | Emphysema  | [ ]  | [ ]  |
| High Cholesterol  | [ ]  | [ ]  | Pneumonia/Lung Infection  | [ ]  | [ ]  |
| Seizures  | [ ]  | [ ]  | Asthma  | [ ]  | [ ]  |
| Other | [ ]  | [ ]  | Other  | [ ]  | [ ]  |

**FAMILY HISTORY** Has any blood relative ever had:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Who** |
| Cancer?  |  [ ]  | [ ]  |  |
| Diabetes?  |  [ ]  | [ ]  |  |
| Bleeding Disorder?  |  [ ]  | [ ]  |  |
| Vascular Problems?  |  [ ]  | [ ]  |  |
| Heart Disease?  |  [ ]  | [ ]  |  |
| Lung Problems?  |  [ ]  | [ ]  |  |
| Other? |  [ ]  |  [ ]  |  |

**SOCIAL HISTORY**

|  |
| --- |
| Do you use Tobacco?  Yes [ ]     No [ ]  If no, have you ever? Yes [ ]     No [ ]  |
| What type?  [ ] Cigarette [ ] Cigar [ ] Snuff [ ] Chewing  |
| If yes, how much                           a day.             How long?                             years  |
| When did you quit? |
| Any history of illegal drug use?  Yes [ ]     No [ ]  If so, what kind? |
| Do you drink alcohol?   Yes [ ]     No [ ]  If so, how much? How often? |