 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 (Non-healing 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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|  |  |  |
|  |  |  |
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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’s 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? |