SAVANNAH VASCULAR INSTITUTE

VASCULAR SPECIALISTS · THE ACCESS CENTER · THE VEIN CENTER

DATE/TIME OF SCHEDULED VISIT:_________________________
CONSULT REQUESTED BY:_________________________________

PATIENT NAME:____ **DATE OF BIRTH:**_________________**AGE:**_______

PAST MEDICAL HISTORY – PLEASE ANSWER ALL AND REMEMBER TO BRING WITH YOU TO YOUR VISIT

REASON FOR COMING TO SEE DOCTOR:_____________________________________

REVIEW OF SYSTEMS

CONSTITUTIONAL
- Fever ☐ yes ☐ no
- Fatigue ☐ yes ☐ no
- Weight gain ☐ yes ☐ no

HEENT
- Change in Vision ☐ yes ☐ no
- Cataracts ☐ yes ☐ no
- Change in Hearing ☐ yes ☐ no
- Headaches ☐ yes ☐ no
- Nose Bleeds ☐ yes ☐ no

RESPIRATORY
- Shortness of Breath ☐ yes ☐ no
- Cough ☐ yes ☐ no
- Lung Disease ☐ yes ☐ no

CVS
- Chest Pain ☐ yes ☐ no
- Breathless on Exert ☐ yes ☐ no
- High BP ☐ yes ☐ no
- Atrial Fib ☐ yes ☐ no
- Heart Attack ☐ yes ☐ no
- Irregular Beats ☐ yes ☐ no
- Pacemaker ☐ yes ☐ no
- Heart Surgery ☐ yes ☐ no
- Heart Angioplasty ☐ yes ☐ no
- Heart Stent ☐ yes ☐ no
- Murmur ☐ yes ☐ no
- Stress Test ☐ yes ☐ no
- High Cholesterol ☐ yes ☐ no
- Cholesterol Meds ☐ yes ☐ no
- Coumadin ☐ yes ☐ no
- Plavix ☐ yes ☐ no
- Aspirin ☐ yes ☐ no

PRIMARY CARE DOCTOR:

HEART DOCTOR:

REVIEW OF SYSTEMS

NEURO
- Memory Loss:
  - Short Term ☐ yes ☐ no
  - Long Term ☐ yes ☐ no
- Pin Stroke ☐ yes ☐ no
- Stroke ☐ yes ☐ no
- Dizziness ☐ yes ☐ no
- Seizure ☐ yes ☐ no
- Trouble Walking ☐ yes ☐ no
  - Walker ☐ yes ☐ no
  - Cane ☐ yes ☐ no

MUSC/SKELETAL
- Joint Pain ☐ yes ☐ no
- Back Pain ☐ yes ☐ no
- Back Surgery ☐ yes ☐ no
- Osteoporosis ☐ yes ☐ no
- Arthritis:
  - Spine ☐ yes ☐ no
  - Hip ☐ yes ☐ no
  - Knee ☐ yes ☐ no
  - Foot & Ankle ☐ yes ☐ no

PVS
- Pain Walking ☐ yes ☐ no
- Sore/Ulcer Leg ☐ yes ☐ no
- Amputation ☐ yes ☐ no
- Prior Blood Clot ☐ yes ☐ no
- Prior Phlebitis ☐ yes ☐ no
- Extremity Swelling ☐yes ☐ no
- Varicose Veins ☐ yes ☐ no
- Support Hose ☐ yes ☐ no

HEMAT/LYMPH/IMMUNO
- Anemia ☐ yes ☐ no
- Free Bleeding ☐ yes ☐ no
- Bruising ☐ yes ☐ no
- Cancer ☐ yes ☐ no
- HIV/Hepatitis ☐ yes ☐ no
- Prior Transfusion ☐ yes ☐ no
- Jehovahs' Witness ☐ yes ☐ no
- Sickle Cell:
  - Disease ☐ yes ☐ no
  - Trait ☐ yes ☐ no

SKIN
- Rash ☐ yes ☐ no
- Cancer ☐ yes ☐ no
- Sore Not Healing ☐ yes ☐ no
- Hair Loss ☐ yes ☐ no

PSYCHOSOCIAL
- Anxiety ☐ yes ☐ no
- Depression ☐ yes ☐ no
- Stress in Life ☐ yes ☐ no

GI
- Vomiting ☐ yes ☐ no
- Nausea ☐ yes ☐ no
- Heart Burn ☐ yes ☐ no
- Constipation ☐ yes ☐ no
- Ulcer Disease ☐ yes ☐ no

OTHER
- Shellfish Allergy ☐ yes ☐ no
- X-Ray Dye Allergy ☐ yes ☐ no
- Trouble With Anesthesia ☐ yes ☐ no

ENDOCRINE
- Diabetes ☐ yes ☐ no
- Insulin ☐ yes ☐ no
- Thyroid Disease ☐ yes ☐ no
- Prednisone ☐ yes ☐ no

GU
- Urinary Frequency ☐ yes ☐ no
- Kidney Problems ☐ yes ☐ no
- Dialysis ☐ yes ☐ no
- Impotence ☐ yes ☐ no
- Incontinence ☐ yes ☐ no

MEDICATIONS
Please attach a list of all of your medications you are currently taking or bring them with you.

OTHER PHYSICIANS
Please attach a list of all of the other doctors you are seeing.

KIDNEY DOCTOR:

DIALYSIS DAYS:

FAMILY HISTORY:
- Heart Disease ☐ yes ☐ no
- Heart Attack ☐ yes ☐ no
- High Blood Pressure ☐ yes ☐ no
- Stroke ☐ yes ☐ no
- Diabetes ☐ yes ☐ no
- Varicose Veins ☐ yes ☐ no
- Blood Clot ☐ yes ☐ no
- Amputation ☐ yes ☐ no
- Bleeding Problems ☐ yes ☐ no
- Anesthesia Problems ☐ yes ☐ no
- Obesity ☐ yes ☐ no
- Cancer ☐ yes ☐ no
- Aneurysm ☐ yes ☐ no

Weight at Age 20:_______ **Weight at Age 40:**_______

Exercise Program: ☐ yes ☐ no

Are you currently on a special diet? ☐ yes ☐ no

Smoker: ☐ yes #Packs per day: ______ #Years:_____
☐ no ☐ quit/date stopped:________________

Alcohol Use: ☐ yes ☐ no

OCCUPATION:

WHO LIVES WITH YOU:

PAST SURGICAL HISTORY

1.____________________________

2.____________________________

3.____________________________

4.____________________________

MEDICATION ALLERGIES: