

Name _____ Date _____ D.O.B. _____

Age _____ Height _____ Weight _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

General: (circle yes or no)

High Blood Pressure Yes No
Diabetes Yes No
Cancer Yes No

Type of Cancer _____

Ulcerative colitis Yes No
Crohn's Disease Yes No
Lupus Yes No
Gout Yes No

Cardiac

Angina Yes No
Pacemaker Yes No
Chest tightness Yes No
Heart Attack Yes No
Sleep on more than one pillow Yes No
Shortness of breath at night Yes No

Lungs

Shortness of breath Yes No
Chronic cough Yes No
Cough up blood Yes No
Cough up mucous Yes No

Gastrointestinal

Diarrhea Yes No
Constipation Yes No
Blood per rectum Yes No

Genitourinary

Problems urinary Yes No
Blood in urine Yes No
Painful urination Yes No
Kidney problems Yes No

Neuro

Stroke Yes No
Memory Loss Yes No
Dizziness Yes No
Temporary paralyzed Yes No
Vision loss in either eye Yes No
Passing out Yes No

Vascular

Legs cramp with walking Yes No
At what distance _____
Gangrene Yes No

List any Surgeries and Date:

Did you have any problems w/ anesthesia
Yes No

Please List All Medications:

Do you have any allergies? Yes No
If so, please list: _____

Please circle if you take one of these medications:

Glucophage Yes No
Coumadin Yes No
Plavix Yes No
Ticlid Yes No

Do you smoke? Yes No
If yes, PPD _____ how long _____

Do you drink? Yes No
If yes, how much _____ how long _____

Is there a family history of heart disease?
Yes No

If yes, who? _____

Present complaint: _____

List all Physicians: _____

Have you or any family members ever seen or had surgery by a CVT doctor? What procedure and whom?
