North Atlanta Vascular Clinic & Vein Center

ALL AREAS MUST BE FILLED OUT COMPLETELY

Today's Date _____/_____/_____ Patient's Name _____

DOB _____/_____/_____ Age _____ Marital Status _____ Referring MD _____

Reason for the visit:

_____

_____

Medical History

Were you ever diagnosed with any of the following? Please check if yes:

□ High Blood Pressure	□ Bleeding Disorders	□ Pulmonary Embolism	□ Neuropathy
□ High Cholesterol	□ Hypothyroidism	□ Heart Attack	□ Aneurysm
□ Arrhythmias	□ Seizure	□ End Stage Renal Disease	□ Kidney Disease
□ Heart Murmur	□ Asthma	□ Varicose Veins	□ Sleep Apnea
□ Diabetes	□ Depression	□ Congestive Heart Failure	□ Cancer: _____
□ Tuberculosis	□ Anxiety	□ Heart Disease	□ Carotid Artery Disease
□ Hepatitis	□ HIV / AIDS	□ Hernia	□ Peripheral Vascular Disease
□ Deep Vein Thrombosis	□ Stroke	□ Angina	□ Peripheral Arterial
□ Anesthesia Complication	□ Liver Disease	□ COPD	□ Other _____

Current Medications: Please list current medications, dosages, and frequency. Include non-prescription, occasionally used medication (i.e. Tylenol, Advil, ect.), and vitamins. **If none please put N/A**

Medication Names:	**Dosage and Frequency**:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies: Please list any allergies to medication, latex, anesthesia, or dye and reactions you have to these medications. **If none please put N/A**

Medication Name:	**Reaction to Medication:**
_____	_____
_____	_____
_____	_____

Surgical/Hospitalization History: Please List any surgical procedures or hospital stays along with the month/year.
If none please put N/A

Month/Year	**Reason/Procedure**
_____/_____	_____
_____/_____	_____
_____/_____	_____
_____/_____	_____
_____/_____	_____
_____/_____	_____

Procedure/Treatment History: Please indicate if you have had any of the following. If yes, provide the date, facility, and explanation on the line provided. ***Please Circle one for each***

Angiogram or Dye Injection	Yes	No	_____
Balloon Angioplasty or Stent	Yes	No	_____
Vena Cava (IVC) Filter	Yes	No	_____
Vascular Ultrasound or CT Scans	Yes	No	_____
Sclerotherapy	Yes	No	_____
Laser Treatment for Veins	Yes	No	_____
Vein Stripping / Ligation	Yes	No	_____
VNUS Closure™	Yes	No	_____
Worn Support Stockings	Yes	No	_____

Are you a **DNR**	YES	NO
Do you have a: **Living Will**	YES	NO
Power of Attorney	YES	NO

Family History: Please check below if any family member(s) has/had any of the following conditions, and indicate the relationship.

- □ High Blood Pressure _____
- □ Diabetes _____
- □ Heart Disease _____
- □ High Cholesterol _____
- □ Stroke _____
- □ Bleeding Disorder _____
- □ Tuberculosis _____
- □ Hepatitis _____
- □ Thyroid Disorder_____
- □ Aneurysm _____
- □ Cancer, indicate type _____
- □ Other _____

Social History ***Please Circle one for each***

Smoking Current / Previous / Never Number of years _____ Packs/Day _____ Year Quit _____

Alcohol Regular / Moderate / Social / Occasional / Never Drinks/Week _____

Illegal/Recreational Drugs Current / Previous / Never Specify Type _____

Exercise Regular / Occasional / None Type and Frequency _____

Occupation _____ **Living With**_____

Review of Systems: Please indicate below if you are CURRENTLY experiencing any of the following symptoms. If yes, explain the circulation and how long you have experienced the symptom. ***Please Circle one for each***

Leg Injury	Yes	No	_____
Leg Pain with Exertion	Yes	No	_____
Leg Pain at Rest	Yes	No	_____
Burning in Legs, Feet, or Toes	Yes	No	_____
Leg or Foot Numbness	Yes	No	_____
Non-healing Sores/Ulcers	Yes	No	_____
Discoloration of Legs/Feet	Yes	No	_____
Recent Weight Change	Yes	No	_____
Fever or Chills	Yes	No	_____
Fatigue	Yes	No	_____
Blurred or Double Vision	Yes	No	_____
Spots before Eyes	Yes	No	_____
Hearing Problems	Yes	No	_____
Chest Pain	Yes	No	_____
Difficulty Breathing	Yes	No	_____
Palpitations	Yes	No	_____
Shortness of Breath	Yes	No	_____
Wheezing	Yes	No	_____
Cough	Yes	No	_____
Painful Breathing	Yes	No	_____
Nausea or Vomiting	Yes	No	_____
Bloody Stool or Urine	Yes	No	_____
Dizziness	Yes	No	_____
Headache	Yes	No	_____
Memory Loss	Yes	No	_____
Numbness	Yes	No	_____
Prolonged Bleeding	Yes	No	_____
Easy Bruising	Yes	No	_____
Swollen Glands	Yes	No	_____

Patient Signature _____ **Date** _____/_____/_____