GEORGIA ENDOVASCULAR

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):			☐ Male ☐ Female	**DOB:**	
Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
How did you hear about us?		☐ Doctor referral		☐ Friend / Family	
☐ Internet search		☐ Insurance plan		☐ Other	
Referring doctor:			**Primary Care Physician:**		
Dermatologist:			**Podiatrist:**		
OB / Gyn:			**Other doctor:**		
Pharmacy:			**Pharmacy Phone Number:**		

HISTORY OF PRESENT ILLNESS: (Please check all that apply)		
☐ Discomfort or fatigue with walking or climbing stairs	☐ Rest from activity helps alleviate discomfort or fatigue in legs	☐ Hair Loss on the Legs
☐ Cramping of the buttocks, thighs or calves with activity	☐ Cramping of the legs at night	☐ Ulcers
☐ Burning	☐ Itching	☐ Achy legs at rest
☐ Numbness or tingling	☐ Leg heaviness	☐ Skin changes/rashes
☐ Leg fatigue with prolonged sitting or standing	☐ Spontaneous bleeding	☐ Leg restlessness
☐ Cellulitis / Skin infection	☐ Pelvic pain	☐ Swelling
☐ Spider veins	☐ Bulging varicose veins	☐ Other
FACTORS THAT MAKE YOUR SYMPTOMS WORSE: (check all that apply)		
☐ Prolonged standing	☐ Prolonged sitting	☐ Warm weather
☐ Menstrual cycle	☐ Pregnancy	☐ Intercourse
☐ Exercise: How far can you walk before you need to stop?	☐ Job requirements:	☐ Other:

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FAMILY HISTORY OF ARTERIAL OR VEIN DISEASE				
☐ Mother	☐ Arterial	☐ Vein	☐ YES	☐ NO
☐ Father	☐ Arterial	☐ Vein	☐ YES	☐ NO
☐ Sibling: Brother / Sister	☐ Arterial	☐ Vein	☐ YES	☐ NO
☐ Grandparent: Maternal / Paternal	☐ Arterial	☐ Vein	☐ YES	☐ NO

SURGERIES	
Year	Operation

PRIOR VASCULAR TREATMENTS: (check all that apply)		
☐ RFA or EVLT vein ablation	☐ Phlebectomy / vein removal	☐ Vein stripping
☐ Vein ligation	☐ Ultrasound guided injections	☐ Spider vein sclerotherapy
☐ Vein harvesting for bypass	☐ Arterial angioplasty	☐ Arterial stent
☐ Arterial bypass	☐ Other	

FACTORS THAT MAKE YOUR SYMPTOMS BETTER: (check all that apply)		
☐ Leg elevation	☐ Exercise	☐ Rest from activity
☐ Compression stockings	Who prescribed compression stockings?	Date prescribed:
☐ Massage	☐ Pain medication	☐ Supplements

OTHER MEDICAL PROBLEMS		
☐ Heart disease / CAD	☐ Peripheral arterial disease	☐ High blood pressure
☐ Stroke / TIA	☐ High cholesterol	☐ Diabetes
☐ COPD	☐ Hole in heart / Patent foramen ovale	☐ Migraines with aura
☐ Blood clot / DVT	☐ Pulmonary embolus / PE	☐ Blood clotting disorder
☐ Kidney disease	☐ Hepatitis	☐ HIV / AIDS
☐ Fibromyalgia	☐ Other	

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MEDICATIONS:	
MEDICATION ALLERGIES:	☐ **No known drug allergies**

FEMALES ONLY:		
Are you pregnant now or plan on becoming pregnant soon?	☐ YES	☐ NO
Are you currently breastfeeding?	☐ YES	☐ NO
Do you have more leg discomfort during your menstrual cycle?	☐ YES	☐ NO
Do you have more pelvic pain during your menstrual cycle?	☐ YES	☐ NO
Do you have pelvic pain which is worse during intercourse?	☐ YES	☐ NO
SOCIAL HISTORY		
Occupation:		
Does your job require prolonged standing?	☐ YES	☐ NO
Does your job require prolonged sitting?	☐ YES	☐ NO
Do your leg symptoms interfere with your work requirements?	☐ YES	☐ NO
Do you currently of have you ever smoked?	☐ YES	☐ NO
If you have smoked regularly, how many years have you smoked?		
If you have ever smoked, how many pack per day?		
How many alcoholic beverages do you consume per week?		

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CURRENT SYMPTOMS

GENERAL
- [ ] Fatigue
- [ ] Fever
- [ ] Weight Loss
- [ ] Weight Gain

EYES
- [ ] Change in Vision
- [ ] Double Vision
- [ ] Pain

EARS, NOSE, THROAT
- [ ] Hearing Loss
- [ ] Ear Pain
- [ ] Nose Bleeds
- [ ] Sore Throat

CARDIOVASCULAR
- [ ] Chest Pain
- [ ] Palpitaions
- [ ] Prior DVT (Blood Clot)
- [ ] Heart Defect

RESPIRATORY
- [ ] Shortness of Breath
- [ ] Cough
- [ ] Wheezing

GASTROINTESTINAL
- [ ] Abdominal Pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] Nausea and Vomiting

GENITOURINARY
- [ ] Increased Urination
- [ ] Urinating at Night
- [ ] Bloody Urine
- [ ] Pelvic Pain
- [ ] Heavy Periods

MUSCULOSKELETAL
- [ ] Leg Pain
- [ ] Leg Swelling
- [ ] Back Pain

SKIN
- [ ] Wounds on Feet
- [ ] Skin Changes
- [ ] Skin Rashes or Itching

HEMATOLOGIC
- [ ] Easy Bleeding
- [ ] Easy Bruising
- [ ] Blood Clots

NEUROLOGIC
- [ ] Restless Legs
- [ ] Numbness or Tingling
- [ ] Headaches (Migraines)
- [ ] Dizziness / Lightheaded
- [ ] Difficulty Walking

PSYCHIATRIC
- [ ] Depression
- [ ] Anxiety
- [ ] Irritability
- [ ] Thoughts of Suicide

ENDOCRINE
- [ ] Frequent Thirst
- [ ] Frequent Urination
- [ ] Brittle Hair
- [ ] Crave Ice
- [ ] Hair Loss

OTHER
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]