

**PATIENT HISTORY
QUESTIONNAIRE**

PAST HISTORY

Did you ever have/had:	Yes	No		Yes	No
Heart Attack			Diverticulitis		
Angina (chest pain)			Hepatitis		
Irregular Heart beat			Cirrhosis		
Congestive Heart Fail.			Epilepsy/Seizures		
High Blood Pressure			Thyroid Disease		
Diabetes			Bladder Infection		
Stroke/TIA			Arthritis		
Claudication (leg pain when walking)			Sciatica		
Leg/Toe Ulcer			Kidney Stones		
Kidney Disease			Bursitis		
Varicose Veins			Yellow Jaundice		
Deep Venous Thrombosis			Gout		
Pulmonary Embolism			Hypercholesterolemia (High Cholesterol)		
Emphysema			Phlebitis		
Asthma			Tuberculosis		
Pneumonia			Anemia		
Bronchitis			Colitis		
Stomach Ulcer			Other		
Hiatal Hernia					

SURGICAL HISTORY

ALLERGIES

Have you ever had:	Yes	No	Allergic to:	Yes	No
Heart Surgery			Penicillin		
Leg Bypass Surgery			Sulfa		
Carotid Endarterectomy			Novocain		
Vein Stripping			Aspirin		
Thyroid Surgery			X-ray Dye		
Appendix Removed			Shellfish		
Gallbladder Removed			Tape		
Hemorrhoids Removed			Other		
Hysterectomy					
Prostate Surgery					
Hernia Repair					
Other					

FAMILY VASCULAR HISTORY

Does anyone in your family have/had: Yes No

ANEURYSM		
Bleeding Problems		
Phlebitis/Deep Vein Thrombosis		
Clotting Problems		
Peripheral Vascular Disease		
Carotid Artery Disease		
Heart Disease		

SOCIAL HISTORY

OCCUPATION:

ALCOHOL USE

Occasionally _____ Weekly _____ Daily _____

TOBACCO USE

Cigarettes	_____ packs	_____ years
Cigars	_____ ea. day	_____ years
Pipe	_____ bowls	_____ years
Have you Quit?	No	Yes/When

NAME _____

DATE _____