VASCULAR WELLNESS INSTITUTE

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NEW PATIENT QUESTIONNAIRE

Date: _____ Referring MD: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home / Cell Phone: _____ Email: _____

Age: _____ Sex: _____ Race: _____ Weight: _____ Height: _____

What is the reason for your visit? _____

ALCOHOL USE (drinks per day): _____

SMOKER: No Yes - packs per day _____ # of years _____

ALLERGIES: _____

MEDICATIONS: Circle and list below, or attach a separate list to this form.

Insulin / Aspirin / Coumadin / Nitroglycerin / Lanoxin (digoxin) / Lasix

Blood pressure medication: None / _____

Other medications: _____

FAMILY HISTORY: circle all that apply

Hypertension Diabetes Heart Attack Stroke High Cholesterol Blood Clots Aneurysms

Other / explain: _____

HAVE YOU EVER HAD:		**Date:**
High Blood Pressure	Y / N	
Diabetes	Y / N	
Heart Attack	Y / N	
Kidney Failure	Y / N	
Liver Failure	Y / N	
Stroke	Y / N	
Blood Clots	Y / N	
Breathing Problems	Y / N	

HAVE YOU HAD ANY PREVIOUS SURGERY? (circle one for each)

		Year			**Year**
Heart Bypass	Y / N		Carotid Endarterectomy	Y / N	
Heart Valve	Y / N		Aneurysm Repair	Y / N	
Leg Bypass	Y / N		Vein Stripping	Y / N	

Other surgery: _____

Please add any other additional information about past medical problems you think the doctor should know:

_____

_____

_____

This section includes questions about problems you are having at the **PRESENT TIME:**
Circle the problems you are having that affect your medical condition.

Do you have…?

Fever	Weight Loss	Loss of appetite	
Blurred Vision	Loss of vision	One eye (R / L)	Both eyes
Chest Pain (angina)	Irregular heartbeat	Heart failure	
Cough	Shortness of breath	Asthma attacks	Emphysema
Nausea	Vomiting	Pain after eating	Diarrhea
	Constipation	Blood in stool	
Frequency urination	Painful urination	Blood in urine	
Stroke	Mini-stroke (TIA)	Dizziness	Blackouts / Seizures
Headaches	Weakness	Arm / Leg	Right / Left
Leg Ulcer	Foot ulcer	Foot infection	Hand or finger?
Pain with walking	Calf / Thigh / Buttock		Right / Left / Both
Pain in the foot or toes			

List any other problems: _____

_____

Please attach or include any other medical information (blood tests, past medical records, etc.) you think may be helpful to the doctor in the evaluation of your problem.

Signature of the person filling out this form: _____

Are you the patient? _____

If not, what is your relationship to the patient? _____

☐ I have reviewed the above data with the patient.

Date: _____ MD: _____