



Kirksey Vascular Associates, P.A.

Specializing in Vascular & Venous Disorders

Medical Information

Date: _____

Name: _____

Address: _____

Phone: _____ Work Phone: _____

Cell Phone: _____ Fax #: _____

E-mail: _____
We will not sell or distribute your email address.

Emergency Contact: (Name): _____ Phone #: _____

Primary Care Physician: _____

Cardiologist: _____ Nephrologist: _____

Dialysis Center: _____

Dialysis Days: _____ MWF _____ TTHS _____

Primary Insurance: _____

Secondary Insurance: _____

Why did you come to the doctor today? _____

Medical History

High Blood Pressure	Y	N	Heart Attack	Y	N
Heart Failure	Y	N	Heart Catheter	Y	N
Heart Stent	Y	N	Stroke	Y	N
Kidney failure	Y	N	Diabetes	Y	N
High Cholesterol	Y	N	Ever Smoke	Y	N
			How much?	_____	
Kidney stones	Y	N			
Other Problems	Y	N			

Surgical History

Gallbladder	Y	N	Appendix	Y	N
Colon Surgery	Y	N	Breast	Y	N
Hysterectomy	Y	N	Ovaries	Y	N
Prostate	Y	N	Kidney Stones	Y	N
Carotid	Y	N	Aortic Surgery	Y	N
Leg Bypass	Y	N	Dialysis	Y	N
Varicose Veins	Y	N	Heart Bypass	Y	N
Lung Surgery	Y	N			

Others _____

Allergies: _____

Current Medications: _____

Social History

Smoking	Y	N	How much per day? _____	How many years? _____
Alcohol	Y	N	How much per day? _____	How many years? _____
Drug	Y	N	How much per day? _____	How many years? _____

Married Divorced Single Widow

Children _____ Y N If yes, how many children?

Occupation: _____ How long? _____

Medical Questions (circle appropriate answer)

- | | | |
|--|---|---|
| 1. Have you ever had a stroke? | Y | N |
| 2. Has one eye ever gone blind? | Y | N |
| 3. Has one side of your face gone numb? | Y | N |
| 4. Has an arm or leg gone numb or weak? | Y | N |
| 5. Have you ever passed out? | Y | N |
| 6. Do your legs hurt when you walk?
If yes, how far before they hurt? _____ | Y | N |
| 7. Does your foot or toes hurt when you sleep?
If yes, which one? _____ If yes, what makes it better? _____ | Y | N |
| 8. Do you have a hand or foot wound that is not healing? | Y | N |
| 9. Does your arm hurt when you use it? | Y | N |
| 10. Do you get dizzy when you use your arm? | Y | N |
| 11. Do you have belly pain after you eat?
If yes, have you lost weight? _____ How much?
_____ | Y | N |
| 12. Have you ever had blood clots? | Y | N |
| 13. Do your legs swell? | Y | N |
| 14. Do you wear support hose? | Y | N |
| 15. Are you on dialysis? | Y | N |
| 16. Have you had dialysis access? | Y | N |