

Kirksey Vascular Associates, P. A.
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Medical History Form

Last Name: _____ First: _____ Date of Birth: _____

Chief Complaint: (Reason for visit today) _____

Location: _____ Quality _____ Modifying Factors: _____

Duration of Problem: _____ Associated Signs/Symptoms: _____

List anything that *Improves* or *Worsens* the problem: _____ Severity (scale from 1-10) _____

Doctor's Notes: _____

Medications (Currently Taking)

Name	Amount	Times/Day

Patient's Medical History

Aortic Aneurysm	Y	N	Diabetic	Y	N
Thoracic Aneurysm	Y	N	Lymphedema	Y	N
Cerebrovascular Disease	Y	N	Hypertension	Y	N
Carotid Artery Disease	Y	N	Atherosclerosis	Y	N
Arm Arterial Disease	Y	N	Vericose Veins	Y	N
Peripheral Arterial (PAD)	Y	N	Spider Veins	Y	N
Venous Insufficiency	Y	N	Cancer	Y	N
Deep Vein Thrombosis	Y	N			

List Any Allergies

Latex	Y	N
Medication Allergies:	None: _____	

Type of Cancer: _____

List any Past Surgeries / Hospitalizations

Type	Date (Year Only)

Family History List Family Member

Aortic Aneurysm	Y	N	
Kidney Disease	Y	N	
Cerebrovascular Disease	Y	N	
Carotid Artery Disease	Y	N	
Hypertension	Y	N	
Diabetes	Y	N	
Atherosclerosis	Y	N	
Cancer	Y	N	
Anesthesia Problems	Y	N	

Social History

Special Diet ?	Y	N
Special Needs (wheelchair, braces, etc.)	Y	N
Other: _____		
Who does patient live with?		

Do you know or have you had any problems related to the following systems?

Circle Yes or No.

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Abnormal Development Y N

Gastrointestinal

Abdominal Pain Y N
 Nausea/Vomiting Y N
 Stool Incontinence Y N
 Constipation Y N
 Blood in Stool Y N

Respiratory (Lungs)

Wheezing Y N
 Frequent Cough Y N
 Shortness of Breath Y N

Eyes

Blurred Vision Y N
 Redness Y N
 Pain Y N

Cardiovascular

Heart Murmur Y N
 High Blood Pressure Y N

Hematologic/Lymphatic

Swollen Glands Y N
 Blood Clotting Problems Y N

Allergic/Immunologic

Hay Fever Y N
 Drug Allergies Y N
 Foods Y N

Integumentary

Skin Rash Y N
 Persistent Itching Y N
 Easy Bruising Y N

Endocrine

Excessive thirst Y N
 Too Hot/Cold Y N
 Tired/Sluggish Y N
 Abnormal Hair Growth Y N

Neurologic

Tremors Y N
 Coordination Problems Y N
 Abnormal Walk Y N

Musculoskeletal

Joint Pain Y N
 Neck Pain Y N
 Back Pain Y N

Ear/Nose/Throat/Mouth

Ear Infection Y N
 Sore Throat Y N
 Sinus Problem Y N

Genitourinary

Painful Urination Y N
 Blood in Urine/Underwear Y N
 Urinary Retention Y N
 Frequent Urination Y N
 Urgency to Urinate Y N

Have you had any X-rays? (Type of test, Date, & Hospital where performed)

TYPE	DATE	HOSPITAL

Do you have any other *Medical Problems* we should know about? Y N

Please list below:

Physician: _____

Date: _____