SOUTH ATLANTA
VASCULAR INSTITUTE

Patient Health Questionnaire

Past Medical History

Do you currently have or been treated in the past for any of the following medical conditions?

_____ Allergies
_____ Aneurysm
_____ Carotid stenosis
_____ Arthritis
_____ COPD
_____ Asthma
_____ Cancer
_____ Diabetes
_____ Thyroid disease
_____ Varicose veins
_____ Wounds/sores
_____ Peripheral vascular disease
_____ Heart failure
_____ High blood pressure
_____ High cholesterol
_____ Kidney disease
_____ Kidney failure
_____ Heart murmur
_____ Heart attack
_____ Chest pain
_____ Stroke
_____ Blood clot
_____ Hepatitis
_____ HIV/AIDS
_____ Dialysis

Please list any other disease or medical condition for which you are being treated or have been treated in the past:

Prior Surgeries or Hospitalizations

Please list any prior surgeries and/or procedures that you have had

Date	Reason for Surgery/Hospitalization	List any complications

Family History

Please indicate if any blood relatives have had any of the following conditions (Indicate relationship)

_____ Diabetes

_____ High blood pressure

_____ Heart disease/heart attack

_____ Aneurysm

_____ Stroke

_____ Varicose veins

_____ Peripheral vascular disease

_____ Kidney disease

_____ Blood clots

_____ Cancer

Allergies

Allergy	What is your reaction

Family History

Please indicate if any blood relatives have had any of the following conditions (Indicate relationship)

_____ Diabetes

_____ High blood pressure

_____ Heart disease/heart attack

_____ Aneurysm

_____ Stroke

_____ Varicose veins

_____ Peripheral vascular disease

_____ Kidney disease

_____ Blood clots

_____ Cancer

Social History

_____ Do you currently smoke

_____ If yes for how long

_____ How many packs per day

_____ Do you drink alcohol

_____If yes how many drinks per week

_____ Any history of illicit drug use

Medications

Please list your current Medications/Vitamins/Supplements

Medication/Vitamin/Supplement	Dosage	Frequency

Review of Systems

General

_____ Fatigue _____ Significant weight loss _____ Chills

_____ Significant weight gain _____ Fever

Vascular (Circulation)

_____ Leg pain with standing _____ Leg pain with walking _____ Skin discoloration

_____ Leg pain with sitting _____ Leg Swelling

Cardiac (Heart)

_____ Chest pain
_____ Fainting
_____ Blood thinner
_____ Anemia
_____ Blood clot
_____ Anemia

Women's Health

_____ Frequent urination
_____ Pelvic pressure
_____ Pain with sex
_____ Pelvic pain
_____ Prolonged bleeding

Renal (Kidney)

_____ Frequent urination
_____ Blood in urine
_____ Flank pain
_____ Kidney stones

Neurologic (Brain)

_____ Weakness
_____ Seizures
_____ TIA
_____ Headaches
_____ Stroke

Respiratory (Lungs)

_____ Cough
_____ Shortness of breath
_____ Snooring
_____ Wheezing
_____ Sleep apnea

Eyes/Ears/Nose and Throat

_____ Glasses/contacts
_____ Nosebleeds
_____ Painful teeth
_____ Blurred vision
_____ Deafness
_____ Vision changes
_____ Hoarseness
_____ Mouth sores
_____ Vision loss/blindness

Psychiatric

_____ Difficulty concentrating
_____ Change in sleeping habits
_____ Anxiety
_____ Tension
_____ Nervousness
_____ Feelings of hopelessness

Gastrointestinal

_____ Constipation
_____ Stomach ulcers
_____ Heartburn
_____ Diarrhea
_____ Abdominal pain

Musculoskeletal/Skin

_____ Dryness
_____ Joint pain
_____ Muscle soreness
_____ Skin discoloration
_____ Joint swelling

_____ Arthritis _____ Muscle weakness

Endocrine

_____ Heat/cold intolerance _____ Weight gain/loss _____ Abnormal hair loss

Patient/Guardian signature: _____

Date: _____ /_____ /_____ Relation to the patient: _____