

Bedford Vascular Associates
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 Bedford, Texas 76022
 Phone: (817) 684-2700
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**Vascular Procedure
 PATIENT HEALTH HISTORY FORM**

Date:		ACCT#:
Last Name:	First Name:	MI:
Date Of Birth:	Age:	Sex:
Social Security #:		

Referring Physician:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS: TO BE COMPLETED BY PHYSICIAN ONLY!!

H1. PAST MEDICAL HISTORY/SURGICAL HISTORY:

- | | | |
|--|------------------------------|-----------------------------|
| 1. COPD/Lung Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Previous Vascular Surgery | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. Stroke | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. Heart Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. Elevated cholesterol | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Diabetes | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. Renal Failure | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. High Blood Pressure | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9. Other medical conditions or
prior surgeries: (If yes, please
list.) | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

H2 REVIEW OF SYSTEMS:

- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | General health (unexplained weight loss, unexplained weight gain, chronic fatigue, change in appetite, fever, chills) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Neurological (seizures, dizziness, previous stroke, TIA, aneurysm, hearing impairment, |

	other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Endocrine/hormonal (thyroid disease, adrenal disease, diabetes)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ophthalmologic (glaucoma, cataracts, visual impairment, blindness, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ears, nose, throat (snoring, hearing aids, ringing in the ears, sinus problems, hoarseness, nose bleeds, seasonal allergies)
PATIENT NAME: _____ DATE: _____	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung/Breathing (wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, coughing up blood, shortness of breath)

<input type="checkbox"/> YES <input type="checkbox"/> NO	Cardiac (Chest pain/angina, congestive heart failure, palpitations, heart attack, ankle swelling, shortness of breath with exertion)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal (hiatal hernia, reflux esophagitis, ulcers, hepatitis, yellow jaundice, gallbladder disease, pancreatic disease, chronic constipation or diarrhea, diverticulitis, GI bleeding, other intestinal disease_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Renal (renal insufficiency, dialysis, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Urological (prostate disease, frequent bladder infections, impotence, kidney stones, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Immunological (rheumatoid arthritis, lupus, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Infectious (AIDS, hepatitis, TB, syphilis, endocarditis, MRSA, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hematologic (anemia, bleeding problem, clotting problem, leukemia, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Psycho/ social (depression, anxiety, non-English speaking)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Physical disability (problems with walking, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dermatologic (psoriasis, eczema, other_____)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vascular (varicose veins, aortic aneurysm)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Malignancy (cancer, tumor, lymphoma)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Musculoskeletal (osteoporosis, joint pain, arthritis, gout, weakness)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Miscellaneous (congenital syndrome, Marfans Turner's, other_____)

H4. ALLERGIES

H5. MEDICATIONS:

Please list all prescription and non-prescription medicines including vitamins and aspirin.

NAME	DOSE/STRENGTH	FREQUENCY

H6. FAMILY HISTORY:

Diabetes Heart disease/ early cardiac death Vascular disease Varicose veins Bleeding problems
 Other: _____

H7. SOCIAL HISTORY: Occupation: _____ Marital Status: _____

Do you smoke? YES NO If yes, how long, how much?

Do you drink alcohol? YES NO Beer/Wine/Hard Liquor #of 8-oz glasses per day

H8. PHYSICAL EXAMINATION:

VITAL SIGNS: WT: HT: PULSE: RESP: BP:

GENERAL:

HEAD:

EYES:

PATIENT NAME: _____ **DATE:** _____

EARS, NOSE AND THROAT:

NECK:

LUNGS:

HEART:

ABDOMEN:

HEMATOLOGIC/LYMPHATIC:

VASCULAR EXAMINATION: CAROTIDS:

UPPER EXTREMITY:

LOWER EXTREMITY:

MUSCULOSKELETAL:

NEUROLOGICAL:

SKIN:

H9. OTHER PHYSICAL FINDINGS:

1.

2.

3.

4.

5.

6.

7.

8.

H10. DIAGNOSTIC DATA:

DIAGNOSES:

1)

2)

3)

4)

IMPRESSION/PLAN/MEDICAL DECISION:

Patient / Family understands Tests / Plan of Care and/or Risks of Surgical Procedure

YES NO

PHYSICIAN

Jerry T. Light, Jr., M.D., F.A.C.S.