PHYSICIANS' CLINIC
of Iowa, P.C.

VASCULAR HEALTH HISTORY QUESTIONNAIRE

Today's Date _____ First Name _____ Last Name _____

Date of Birth _____ Language _____ Height (feet/inches) _____ Weight (pounds) _____

Reason for today's appointment (symptoms, onset, duration): _____

_____

Recent tests or x-rays (when and where): _____

_____

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____

Date of last influenza vaccination _____ Date of last pneumonia vaccination _____

If you are 50 years old or older, date of your last colonoscopy _____ Date of last mammogram _____

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐ See attached list for additional medications)	Dose	Frequency

ALLERGIES: Please list any allergies (☐ See attached list for additional allergies)

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No Describe Reaction: _____

PAST HEALTH HISTORY: *(Check all that apply)*

☐ Arthritis
☐ Blood Clots
☐ Cancer/Type _____
☐ Depression/Psychiatric Disorders
☐ Diabetes Mellitus
☐ Eye Conditions
☐ Glucose Monitor
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol or Lipids
☐ Kidney Disease
☐ Liver Disease/Hepatitis
☐ Lung Disease/Asthma
☐ MRSA/VRE
☐ Obstructive Sleep Apnea
☐ Received Blood in Past
☐ Stomach/Intestinal Problems
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Ulcers
☐ Vascular Disease

Other Medical Conditions (please list): _____

_____

_____

Continued on back →

PAST SURGICAL HISTORY: Please check any previous surgeries/hospitalizations and list the date/place they occurred:

☐ Appendix _____
☐ Bladder _____
☐ Cataract _____
☐ Child Birth _____
☐ Colon _____
☐ Ear _____
☐ Gallbladder _____
☐ Heart _____
☐ Hernia Repair _____
☐ Hysterectomy _____
☐ Joint Replacement _____
☐ Kidney _____
☐ Lung _____
☐ Nasal/Sinus _____
☐ Neck _____
☐ Oophorectomy _____
☐ Pacemaker _____
☐ Prostate _____
☐ Testicle _____
☐ Throat _____
☐ Tonsillectomy _____
☐ Urinary Stone _____
☐ Vasectomy _____
☐ Vascular Surgery _____

☐ Other (please describe) _____
☐ Hospitalization other than surgery _____

FAMILY HISTORY: Has any member of your immediate family (father/mother/brother/sister/son/daughter) ever had the following conditions. If yes, indicate family member.

	Family Member		Family Member
☐ Aneurysm	_____	☐ Lung Disease (COPD)	_____
☐ Arthritis	_____	☐ Stroke	_____
☐ Cancer (include type)	_____	☐ Stomach/Intestinal Problems	_____
☐ Diabetes Mellitus	_____	☐ Ulcers	_____
☐ Heart Disease	_____	☐ Blood Clots	_____
☐ High Cholesterol/Lipids	_____	☐ Blood Coagulation Disorder	_____
☐ Liver Disease/Hepatitis	_____	☐ Varicose Veins	_____
☐ High Blood Pressure	_____		
☐ Kidney Disease	_____	Mother ☐ Alive ☐ Deceased Age: _____	
		Father ☐ Alive ☐ Deceased Age: _____	

☐ Unable to obtain family history due to adoption or other circumstances.

SOCIAL HISTORY:

Alcohol/Drug Use:

Do you use alcohol? ☐ Yes ☐ No How many drinks per day? _____
Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No If yes, ☐ Current ☐ Past

Tobacco Use:

☐ Yes ☐ No Current Smoker How much/how long? _____
☐ Yes ☐ No Former Smoker/Date Quit _____
☐ Yes ☐ No Chewing Tobacco
☐ Yes ☐ No Vaping
☐ Yes ☐ No Never Smoked