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 |
|---|---|---|
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**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: _____

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

☐ Yes ☐ No Appendix _____
☐ Yes ☐ No Bladder _____
☐ Yes ☐ No Cataract _____
☐ Yes ☐ No Child Birth _____
☐ Yes ☐ No Colon _____
☐ Yes ☐ No Ear _____
☐ Yes ☐ No Gallbladder _____
☐ Yes ☐ No Heart _____
☐ Yes ☐ No Hernia Repair _____
☐ Yes ☐ No Hysterectomy _____
☐ Yes ☐ No Joint Replacement _____

☐ Yes ☐ No Kidney _____
☐ Yes ☐ No Lung _____
☐ Yes ☐ No Nasal/Sinus _____
☐ Yes ☐ No Neck _____
☐ Yes ☐ No Oophorectomy _____
☐ Yes ☐ No Prostate _____
☐ Yes ☐ No Testicle _____
☐ Yes ☐ No Throat _____
☐ Yes ☐ No Tonsillectomy _____
☐ Yes ☐ No Urinary Stone _____
☐ Yes ☐ No Vasectomy _____
☐ Yes ☐ No Vein Treatment _____

☐ Other (please describe) _____

*Continued on back →*

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

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Blood Clots
☐ Yes ☐ No Cancer/Type _____
☐ Yes ☐ No Depression/Psychiatric Disorders
☐ Yes ☐ No Diabetes Mellitus
☐ Yes ☐ No Eye Conditions
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No High Cholesterol or Lipids
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease/Hepatitis
☐ Yes ☐ No Lung Disease/Asthma
☐ Yes ☐ No MRSA/VRE
☐ Yes ☐ No Obstructive Sleep Apnea
☐ Yes ☐ No Received Blood in Past
☐ Yes ☐ No Stomach/Intestinal Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Disorder
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers

Other Medical Conditions (please list): _____

_____

**SOCIAL HISTORY:**

***Occupation:***

_____

☐ Yes ☐ No Retired
☐ Yes ☐ No Currently Disabled
☐ Yes ☐ No Working Full Time
☐ Yes ☐ No Working Part Time
☐ Yes ☐ No Unemployed
☐ Yes ☐ No Student

***Marital Status:***

☐ Yes ☐ No Single
☐ Yes ☐ No Currently Married/ Partnered
☐ Yes ☐ No Divorced
☐ Yes ☐ No Widowed

Spouse/Partner Name:
_____

***Alcohol/Drug Use:***

Do you use alcohol? ☐ Yes ☐ No
How many drinks per week? _____
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 Chewing Tobacco
☐ Yes ☐ No Former Smoker/Date Quit
_____
☐ Yes ☐ No Never Smoked

**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 |
|---|---|---|
| ☐ Yes ☐ No | Arthritis | _____ |
| ☐ Yes ☐ No | Cancer (include type) | _____ |
| ☐ Yes ☐ No | Diabetes Mellitus | _____ |
| ☐ Yes ☐ No | Eye Conditions | _____ |
| ☐ Yes ☐ No | Heart Disease | _____ |
| ☐ Yes ☐ No | High Cholesterol/Lipids | _____ |
| ☐ Yes ☐ No | Liver Disease/Hepatitis | _____ |
| ☐ Yes ☐ No | High Blood Pressure | _____ |
| ☐ Yes ☐ No | Kidney Disease | _____ |

| | | Family Member |
|---|---|---|
| ☐ Yes ☐ No | Lung Disease (COPD) | _____ |
| ☐ Yes ☐ No | Stroke | _____ |
| ☐ Yes ☐ No | Stomach/Intestinal Problems | _____ |
| ☐ Yes ☐ No | Ulcers | _____ |
| ☐ Yes ☐ No | Blood Clots | _____ |
| ☐ Yes ☐ No | Blood Coagulation Disorder | _____ |
| ☐ Yes ☐ No | Varicose Veins | _____ |
| ☐ Yes ☐ No | Vein Stripping | _____ |

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