PHYSICIANS' CLINIC
of Iowa, P.C.

VASCULAR 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 _____

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

☐ Current smoker -- How much/how long? _____ ☐ Chewing tobacco ☐ Former smoker -- Date quit _____ ☐ Never smoked

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General
☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Heavy Sweating/Night Sweats
☐ Yes ☐ No Loss of Appetite
☐ Yes ☐ No Sleep Disturbances
☐ Yes ☐ No Unexplained Weight Loss/Gain
☐ Other: _____

Eyes
☐ Yes ☐ No Blurry Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Wear Glasses
☐ Other: _____

Ear/Nose/Throat
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Mouth Sores
☐ Yes ☐ No Nasal Congestion/Sinus Issues
☐ Yes ☐ No Hearing Loss
☐ Other: _____

Respiratory
☐ Yes ☐ No Cough
☐ Yes ☐ No COPD
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Recurrent Respiratory Infections
☐ Yes ☐ No Shortness of Breath
☐ Other: _____

Endocrine
☐ Yes ☐ No Excessive Thirst/Fluid Intake
☐ Yes ☐ No Temperature Intolerance
☐ Yes ☐ No Feeling Tired (Fatigue)
☐ Yes ☐ No Hot Flashes
☐ Other: _____

Genitourinary
☐ Yes ☐ No Painful urination
☐ Yes ☐ No Urinary Frequency
☐ Yes ☐ No Loss of Urinary Control
☐ Yes ☐ No Enlarged Prostate
☐ Yes ☐ No Difficulty Urinating
☐ Other: _____

Skin
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Itching
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Lumps or Masses
☐ Other: _____

Musculoskeletal
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Joint Swelling
☐ Yes ☐ No Back Pain
☐ Yes ☐ No Limitation of Motion
☐ Yes ☐ No Neck Pain
☐ Yes ☐ No Pain with Walking
☐ Other: _____

Cardiovascular
☐ Yes ☐ No Chest Pain or Discomfort
☐ Yes ☐ No Swelling Feet, Ankles, Legs
☐ Yes ☐ No Irregular Heartbeat
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Varicose Veins
☐ Other: _____

Pain
Current pain rating (0-10) _____
Location _____

Hematologic/Lymphatic
☐ Yes ☐ No Swollen Glands
☐ Yes ☐ No Blood Clotting Problem
☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Bleeding Tendencies
☐ Other: _____

Neurological
☐ Yes ☐ No Tremors
☐ Yes ☐ No Dizzy Spells
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Headache
☐ Yes ☐ No Unsteady Gait
☐ Yes ☐ No Feeling Weak
☐ Yes ☐ No Convulsions/Seizures
☐ Other: _____

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Indigestion/Heartburn
☐ Yes ☐ No Blood in Stools
☐ Yes ☐ No Change in Bowel Habits
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Swallowing Difficulties
☐ Other: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.

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VASCULAR HISTORY: *(please check all that apply)*

Do you have or have you ever been diagnosed with:

☐ Blood Clots	Leg: ☐ R ☐ L	
☐ Deep Vein Thrombosis (DVT)	Leg: ☐ R ☐ L	
☐ Phlebitis (Vein Redness/Tenderness)	Leg: ☐ R ☐ L	
☐ Saphenous Vein Reflux	Leg: ☐ R ☐ L	
☐ Varicose Vein Problems	Leg: ☐ R ☐ L	

Do you experience any of the following in your legs?

☐ Aching/Pain	Leg: ☐ R ☐ L	☐ Skin or Ulcer Problems	Leg: ☐ R ☐ L
☐ Cramps	Leg: ☐ R ☐ L	☐ Swelling	Leg: ☐ R ☐ L
☐ Heaviness	Leg: ☐ R ☐ L	☐ Throbbing	Leg: ☐ R ☐ L
☐ Itching/Burning	Leg: ☐ R ☐ L	☐ Tiredness/Fatigue	Leg: ☐ R ☐ L
☐ Restless Legs	Leg: ☐ R ☐ L	☐ Other: _____	Leg: ☐ R ☐ L

Which of the following do you currently do to improve your leg vein symptoms:

☐ Yes ☐ No Elevation of legs Please explain: _____

☐ Yes ☐ No Medication for pain Please explain: _____

☐ Yes ☐ No Wear support hose Please explain: _____

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		Family Member
☐ Yes ☐ No	Blood Clots	_____
☐ Yes ☐ No	Blood Coagulation Disorder	_____
☐ Yes ☐ No	Stroke, Heart Attack, or Pulmonary Embolism	_____
☐ Yes ☐ No	Varicose Veins	_____
☐ Yes ☐ No	Vein Stripping	_____

VEIN TREATMENT HISTORY:

Have you ever been treated for varicose veins?

☐ Yes

If yes, what procedure? _____

_____

☐ No

PERSONAL ACTIVITIES LIST:

(please check all that apply)

☐ Yes ☐ No My work requires me to stand for prolonged periods of time.

☐ Yes ☐ No My work requires me to sit for prolonged periods of time.

☐ Yes ☐ No I exercise regularly.