VVS
VASCULAR & VEIN SPECIALISTS
OF GREENSBORO

Today's Date_____

Thank you for choosing Vascular and Vein Specialists for your medical care. In order for us to provide the best care possible, please complete the following information. If you need additional space, please use the back of the form.

What is your name? _____

What is your date of birth? _____

Who is your current Primary/ Family Care doctor? _____

Who referred you to our office? _____

Why are you seeing us, today?

_____

Review of Symptoms

What types of problems have you been experiencing? (Check all that apply)

Cardiovascular:
- □ chest pain
- □ chest pressure
- □ palpitations
- □ shortness of breath when lying flat
- □ shortness of breath with exertion
- □ pain in legs with walking
- □ pain in feet when lying flat
- □ history of blood clot in veins (DVT)
- □ history of phlebitis
- □ swelling in legs
- □ varicose veins

Pulmonary:
- □ productive cough
- □ asthma
- □ wheezing

Neurologic:
- □ weakness in arms or legs
- □ numbness in arms or legs
- □ difficulty speaking or slurred speech
- □ temporary loss of vision in one eye
- □ dizziness

Hematologic:
- □ bleeding problems
- □ problems with blood clotting too easily

Gastrointestinal:
- □ vomiting blood
- □ blood in stool

Genitourinary:
- □ burning with urination
- □ blood in urine

Psychiatric:
- □ history of major depression

Integumentary (Skin):
- □ rashes
- □ ulcers

Constitutional:
- □ fever
- □ chills

Today's Date_____ Last Name_____

Medical History

Have you ever been told that you have any of the following medical problems?

	Yes	No	
• Anemia	☐	☐	
• Arterial Fibrillation (irregular heartbeat)	☐	☐	
• Congestive Heart Failure	☐	☐	
• COPD or Emphysema	☐	☐	
• Coronary Artery Disease (heart disease)	☐	☐	
• Stroke/Ministroke	☐	☐	
• Diabetes	☐	☐	
• Deep Vein Thrombosis (blood clot in veins)	☐	☐	
• HIV/AIDS	☐	☐	
• Kidney Disease	☐	☐	
• MI (myocardial infection/ heart attack	☐	☐	
• PVD (artery blockage or artery disease)	☐	☐	
• Cancer	☐	☐	What Type_____

Past Surgical History

Have you ever had any of the following surgeries?

	Yes	No		
• Bypass (Artery Surgery)	☐	☐	When_____	
• CABG (Open Heart Surgery)	☐	☐	When_____	
• Joint Replacement	☐	☐	When_____	What Type_____
• Heart Valve Surgery	☐	☐	When_____	
• Abdomen Surgery	☐	☐	When_____	What Type_____
• Any Other Surgery	☐	☐	When_____	What Type_____

_____

Family History

Who in your family has had the following? Check all the apply

	Mother	Father	Sister	Brother	Daughter	Son
Cancer						
DVT (blood Clot in Vein						
Diabetes						
Heart Disease						
High Cholesterol						
High Blood Pressure						
Heart Disease before the age of 60						
Varicose Veins						
Heart Attack						
Peripheral Vascular Disease/leg bypass						
Bleeding Problems						
Amputation						
AAA (abdominal aneurysm)						

Today's Date_____ **Last Name**_____

Social History

	Yes	No	
Do you currently use tobacco?	☐	☐	**If yes, what kind?** _____
			How long? _____
			Do you want to quit? Yes ☐ No ☐
Have you used tobacco in the past?	☐	☐	**If yes, when did you quit?** _____
Do you drink alcohol?	☐	☐	**If yes, tell us how many:**
			Glasses of wine/week _____
			Cans of beer per week _____
			Shots of liquor/week _____
			Other kinds of alcohol _____
Do you currently abuse drugs?	☐	☐	**If yes, for how long?** _____
			What type? _____
			Do you want to quit? Yes ☐ No ☐
Have you ever abused drugs in the past?	☐	☐	**If yes, when did you quit?** _____

What is your Marital Status?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

	Yes	No		
Do you have children?	☐	☐	Ages_____	
Are you working currently?	☐	☐	I'm Retired ☐	I'm Disabled ☐

What is/was your occupation?_____