VALLEY VASCULAR ASSOCIATES INC.

PERSONAL MEDICAL HISTORY

(Please complete both pages as accurately as possible)

NAME:____ CHART NUMBER:____________________

Today's Date:________________ Age:_______ Sex________ Height:_____ DOB:______/_______/_____

Marital Status: □Married □Single □Separated □Divorced □Widowed Occupation:______________

PLEASE LIST YOUR IMMIDIATE COMPLAINTS:

ALLERGIES: ○ NONE ○ YES, LIST INCLUDING MEDICATIONS, FOOD, POLLENS		

CURRENT MEDICATIONS & DOSE ○ NONE		
1-	6-	11-
2-	7-	12-
3-	8-	13-
4-	9-	14-
5-	10-	15-

PAST ILLNESSES-	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Measles				Mumps				Migraine Headaches			
Rubella				Rheumatic Fever				Chronic Kidney Disease			
Mononucleosis				Meningitis				Hernia			
Pneumonia				Diabetes				Syphilis			
Emphysema				Thyroid Disease				Other Venereal Disease			
Asthma				Arthritis				Broken Bones			
Bronchitis				Gout				Nervous Breakdown			
Kidney Stone				Cancer (type:)				Suicide Attempts			
Kidney Infection				Colitis				Depression (requiring meds)			
Ulcers				Diverticulitis				Drug/ Alcohol Abuse			
Hepatitis				Irritable/Spastic bowel				Major Head Injury			
Liver Disease				Heart Attack				Transfusion			
Gallbladder Disease				Heart Murmur				Other Major Illnesses/injuries			
AIDS				Stroke							
Bleeding Tendencies				High Blood Pressure							
Tuberculosis				Heart Problem							
Positive TB Test				Epilepsy / Seizures							

Males Only	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Enlarged Prostate				Prostate Infection				Epididymitis			
Uterine Problem				Urine Infection				Other -			

Females Only	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Abdominal Pap Smear											
Uterine Fibrosis											
PMS											
Age at First Period-											

Past Surgeries (type / year) ○ NONE		SERIOUS ACCIDENTS: ○NONE
1-	4-	1-
2-	5-	2-
3-	6-	3-

PAST EXAM (Date:)	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Physical				Stool Hematest				Mammogram			
Pap Smear				Sigmoidoscopy				TB Test			

FAMILY HISTORY:	If Living, Age & Health	If Deceased, Age at Death & Cause	HAS ANY BLOOD RELATIVE HAD:	Yes	No	Who:
Father's Father:			Heart Attack			
Father's Mother:			Heart disease			
Mother's Father:			High blood pressure			
Mother's Mother:			Stroke			
Father:			Breast Cancer			
Mother:			Cancer			
Brother(s):			Type -			
			Insulin Diabetes			
			Non-Insulin Diabetes			
Sister(s):			Sickle Cell Disease			
			Asthma			
			Tuberculosis			
Son(s):			Thyroid Disease			
			Emotional Disorder			
			Alcohol/Drug Abuse			
Daughter(s):			Migraine Headaches			
			Bleeding Tendencies			
			Other:			
Spouse:						

HABITS: SMOKING	Yes	No
Do you smoke now?		
Did you ever smoke?		

How much do/did you smoke: (packs per day)

For how long? (years)

What do/did you smoke? ○ Cigarettes ○ Cigars ○ Pipe

DRINKING	Yes	No
Do you drink alcohol?		
Have you ever had a drinking problem?		

How often do you drink alcohol? ○ rarely ○ 1x/month ○ 1x/week ○ more than 5x/week

What do you drink? How many cups of coffee a day?

DRUGS	Yes	No
Do you use recreational drugs?		

What do you use?

How often? ○ rarely ○ monthly ○ weekly ○ daily

EXCERCISE	Yes	No
Do you exercise regularly		

What type of exercise?

How often?