Fayetteville Vascular and Vein Center, P.A

Michael A. Leke
American Board of Surgery Certified
Vascular and Endovascular Surgery

HEALTH HISTORY

TO BE COMPLETED BY PATIENT

Name: _____DOB: _____Date: _____

Reason for Visit: _____ Primary Care Physician: _____

Medical Problems - Please indicate if you are currently experiencing any of the following: (√)

None	Cirrhosis of liver	Gallstones	Kidney disease/failure	Stroke/paralysis
Anemia	Colon Cancer	Heartburn	Kidney Stone	Thyroid problems
Anxiety	Colon Polyps	Hepatitis-Type___	Osteoporosis	Other: _____
Arthritis	Crohn's Disease	Hiatal Hernia	Pancreatitis	
Asthma	Depression	High Blood Pressure	Parkinson's Disease	
Cataracts	Diabetes	High cholesterol	Rheumatic Fever	
Chronic cough	Diverticulosis	Irregular heartbeat	Seizure	
Chronic lung disease	Fibromyalgia	Irritable bowel syndrome	Stomach/duodenal ulcer	

Surgeries/Procedures – Please indicate if you have previously had a surgery or procedure: (√)

None	C-section	Hiatal Surgery	Prostate
Appendectomy	Dialysis access surgery	Hysterectomy	Stomach
Breast surgery-KIND_____		Joint replacement	Thyroid
Cardiac Surgery	Endoscopy (EGD)-Date: _____		Tonsillectomy
Colon resection	Gallbladder surgery	Liver biopsy	Tubal ligation
Colonoscopy-Date	Hemorrhoidectomy	Obesity surgery	Other: _____

Social History: (√)

Marital Status: Single Married Divorced Widow

Current Occupation: _____Employer: _____

Do you currently smoke? _____ If you've smoked previously, when did you stop? _____
How many packs per day? _____ For how many years? _____ Do you drink alcohol? _____ How many per day? _____
per week? _____ per month? ____ Do you use illicit drugs? _____ If yes, what kind? _____

Family History: (√)

History of Heart disease (heart attack, heart failure)? Yes No Whom: _____

History of Strokes? Yes No Whom: _____

History of High Blood Pressure? Yes No Whom: _____

History of Diabetes? Yes No Whom: _____

History of Cancer? Yes No Whom: _____

HEALTH HISTORY

Allergies: (√) NONE Aspirin Morphine Penicillin Sulfa Versed Valium Shellfish IVP Dye Other:_____

Medications: Please include **STRENGTH &DOSAGE**

Medication Name	**Dosage (Amount)**	**Frequency (How Often)**
Example: Lipitor	*10mg*	*2x per day*

Do you take any non-prescription medicines, herbal remedies, or tonics? (e.g. laxatives, diet pills, vitamins, antacids, or cold remedies) Yes No If yes, specify below

Name of Medicine, Remedy, Tonic, etc.	**Dosage (Amount)**	**Frequency (How Often)**
Example: Multivitamin	*1 pill*	*1x per day*

Review of Systems: Please indicate if you are currently experiencing the following: (√)

General: None Fevers Chills Sweats Fatigue Malaise Weight Loss

Eyes: None Blurring Diplopia (Double Vision) Irritation Discharge Vision Loss Eye Pain

Ears/Nose/Throat: None Earache Ear Discharge Tinnitus (Ringing in Ear) Decreased Hearing Nasal Congestion Nosebleeds Sore Throat Hoarseness Dysphagia (Difficult Swallowing)

Cardiovascular: None Chest Pain Palpitations Syncope (Passing Out) Dyspnea On Exertion (Shortness of Breath) Orthopnea (Shortness of Breath When Lying Down) Peripheral Edema (Leg Swelling)

Respiratory: None Cough Dyspnea (Shortness of Breath) Excessive Sputum Hemoptysis Wheezing

Gastrointestinal: None Nausea Vomiting Diarrhea Constipation Change In Bowel Habits Abdominal Pain Melena (Black Stool) Hematochezia (Rectal Bleeding) Heartburn Jaundice (Yellow Skin)

Genitourinary: None Vaginal Discharge Incontinence Dysuria (Painful Urination) Hematuria (Bloody Urination) Urinary Frequency Amenorrhea (No Menstruation) Menorrhagia (Heavy Menstruation) Abnormal Vaginal Bleeding Pelvic Pain

Musculoskeletal: Non Back Pain Joint Pain Joint Swelling Muscle Cramps Muscle Weakness Stiffness Arthritis

Skin: None Rash Itching Dryness Tattoo (S)

Neurologic: None Transient Paralysis Weakness Seizures Syncope (Passing Out) Tremor Vertigo

Psychiatric: None Depression Anxiety Memory Loss Suicidal Ideation Hallucinations Paranoia

Endocrine: None Cold Intolerance Heat Intolerance Polydipsia (Excessive Thirst) Polyuria (Excessive Urination)

Heme/Lymphatic: None Abnormal Bruising Bleeding Enlarged Lymph Nodes

Allergic/Immunologic: Non Urticarial (Itching) Hay Fever HIV Exposure Eczema

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____