Patient Health Questionnaire

Vascular SURGICAL SPECIALISTS, PLLC

Name:_____ DOB:_____ Date:_____

Age:_____ Height:_____ Weight:_____ Reason for Visit?_____

Referring Provider:

_____

Address:_____

_____

Phone: ( )_____

Family Doctor:_____

Phone: ( )_____

Cardiologist:_____

Phone: ( )_____

Other:_____

Phone: ( )_____

Medications

Please list your medications with dosages (include all prescription, non-prescription and herbal treatments).

_____

_____

_____

_____

_____

_____

_____

_____

Allergies/Reaction

Please list any allergies including those to drugs, latex, adhesive tape, food, etc. and include your reaction:

_____

_____

_____

_____

Have you had any of the following?
Please check appropriate boxes.

Past Medical History

- ☐ High Blood Pressure
- ☐ Acute Myocardial Infarction
- ☐ A-Fib If so, Onset Date:_____
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Venous Thrombosis (DVT)
- ☐ Ischemic Vascular Disease Onset Date:_____
- ☐ Cancer Type:_____
  Onset Date:_____
- ☐ High Cholesterol
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder Type:_____
- ☐ Esophageal Reflux
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Renal Failure
- ☐ Blood Disorder Type:_____
- ☐ HIV Infection
- ☐ Hepatitis
- ☐ Other:_____

Social History

Current Smoker: ☐ Y ☐ N

Packs per day?_____ No. of years?_____

Former Smoker: ☐ Y ☐ N

Year you quit:_____

Other Tobacco Use? ☐ Y ☐ N

Type?_____

Alcohol Use: ☐ Y ☐ N

Frequency?_____

Recreational Drug Use: ☐ Y ☐ N

Type/frequency?_____

Name: _____

Family History

If relationship is other than immediate family member, please identify relationship and indicate "M" for Maternal or "P" for Paternal.

Cancer: ☐ Y ☐ N

Type: _____

Relationship: _____

Heart Disease: ☐ Y ☐ N

Relationship: _____

High Blood Pressure: ☐ Y ☐ N

Relationship: _____

Diabetes Mellitus: ☐ Y ☐ N

Relationship: _____

Other: ☐ Y _____

Past Surgical History

Please list the date and type of any previous surgery:

_____

_____

_____

_____

_____

_____

Have you had a Colectomy (Colon Resection)?

If yes, when? _____

Have you had a Mastectomy?

☐ Left ☐ Right ☐ Bilateral

If yes, when?

_____

Have **you** ever had a problem with anesthesia? (please explain)

_____

_____

Have any of your **family members** ever had a problem with anesthesia? (please explain)

_____

_____

Do you currently have any of the following?

General Symptoms

☐ Y ☐ N Significant Weight Change
If yes, indicate gained or lost? _____
Amount? _____

☐ Y ☐ N Increase in Appetite

☐ Y ☐ N Decrease in Appetite

☐ Y ☐ N Fever

☐ Y ☐ N Chills

☐ Y ☐ N Tiring Easily

Skin Symptoms

☐ Y ☐ N Itching

☐ Y ☐ N Skin Lesions

☐ Y ☐ N Rashes

☐ Y Other: _____

Head Symptoms

☐ Y ☐ N Headache

☐ Y ☐ N Corrective Lenses

☐ Y Other: _____

Neck Symptoms

☐ Y ☐ N Neck Pain

☐ Y ☐ N Neck Stiffness

☐ Y ☐ N Lump or Swelling

☐ Y Other: _____

Otolaryngeal Symptoms

☐ Y ☐ N Earache

☐ Y ☐ N Hearing Loss

☐ Y ☐ N Nosebleeds

☐ Y ☐ N Mouth Sores

☐ Y ☐ N Bleeding Gums

☐ Y ☐ N Hoarseness

☐ Y ☐ N Throat Pain

☐ Y Other: _____

Name: _____

Cardiovascular

☐ Y ☐ N Chest Pain or Discomfort
☐ Y ☐ N Fast Heart Rate
☐ Y ☐ N Palpitations
☐ Y Other: _____

Pulmonary Symptoms

☐ Y ☐ N Wheezing (Asthma)
☐ Y Other: _____

Endocrine Symptoms

☐ Y ☐ N Excessive Sweating
☐ Y ☐ N Excessive Thirst
☐ Y Other: _____

Hematologic Symptoms

☐ Y ☐ N Easy Bleeding
☐ Y ☐ N Easy Bruising Tendency
☐ Y Other: _____

Gastrointestinal Symptoms

☐ Y ☐ N Difficulty Swallowing
☐ Y ☐ N Heartburn
☐ Y ☐ N Ulcer
☐ Y ☐ N Nausea
☐ Y ☐ N Vomiting
☐ Y ☐ N Abdominal Pain
☐ Y ☐ N Bowel/Bladder Changes
☐ Y ☐ N Diarrhea
☐ Y ☐ N Constipation
☐ Y ☐ N Black or Tarry Stools
☐ Y ☐ N Rectal Bleeding
☐ Y Other: _____

Genitourinary Symptoms

☐ Y ☐ N Pain During Urination
☐ Y ☐ N Increased Urinary Frequency
☐ Y ☐ N Blood in Urine
☐ Y ☐ N Genital Lesion
☐ Y Other: _____

Musculoskeletal Symptoms

☐ Y ☐ N Joint Pain
☐ Y ☐ N Joint Stiffness
☐ Y ☐ N Muscle Aches
☐ Y Other: _____

Neurological Symptoms

☐ Y ☐ N Dizziness
☐ Y ☐ N Vertigo
☐ Y ☐ N Fainting
☐ Y ☐ N Motor Disturbances
☐ Y ☐ N Sensory Disturbances
☐ Y Other: _____

Psychological Symptoms

☐ Y ☐ N Sleep Disturbances
☐ Y ☐ N Anxiety
☐ Y ☐ N Depression
☐ Y Other: _____

Female Patients Only:

Date of Last Menstrual Period _____
Are you pregnant? If so, when is your due date? _____

Immunization and Screening History

All patients[1]

When was your last flu vaccination?

Date _____

All patients 65 or older[2]

Have you ever received a pneumonia vaccination? ☐ Y ☐ N

Approximate Date _____

All patients ages 50-75[3] (Please Circle Test)

When was your last Colonoscopy, Sigmoidoscopy or Fecal Occult Blood Test?

Date _____

Female patients age 40 or older[4]

When was your last mammogram?

☐ Left ☐ Right ☐ Bilateral

Date _____

[1] Surgical Specialists recommends you obtain an annual flu vaccine.

[2] Surgical Specialists recommends you receive a pneumonia vaccine if you are age 65 or older and have not yet received one.

[3] Surgical Specialists recommends you have a colorectal screening every 10 years unless otherwise indicated by your family doctor or specialist.

[4] Surgical Specialists recommends you have a yearly screening mammogram.