

Iowa City Thoracic & Vascular Patient History Form

Patient Name: _____ Date: _____ DOB: _____

Allergies: _____

What is the reason for your visit?

List Surgeries/Serious Injuries

Past Medical History

Have you ever had the following?

Diabetes	yes	no
Hypertension	yes	no
Cancer	yes	no
Stroke	yes	no
Heart Disease	yes	no
High Cholesterol	yes	no
Blocked Arteries	yes	no
Easy Bleeding	yes	no
Blood Clots	yes	no
Emphysema/COPD	yes	no
Asthma	yes	no
Hepatitis	yes	no
Kidney Disease	yes	no
Blood Transfusion	yes	no
Varicose Veins	yes	no
Leg Ulcers	yes	no
Bronchitis	yes	no

Family History

Have any family members had the following?

	yes	no	Who?
Diabetes	yes	no	_____
Hypertension	yes	no	_____
Cancer	yes	no	_____
Stroke	yes	no	_____
Heart Disease	yes	no	_____
High Cholesterol	yes	no	_____
Blocked Arteries	yes	no	_____
Easy Bleeding	yes	no	_____
Blood Clots	yes	no	_____
Emphysema/COPD	yes	no	_____
Asthma	yes	no	_____
Hepatitis	yes	no	_____
Kidney Disease	yes	no	_____
Blood Transfusion	yes	no	_____
Varicose Veins	yes	no	_____
Leg Ulcers	yes	no	_____
Bronchitis	yes	no	_____

List medications, dose and reason for taking.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

Occupational Exposure

Any occupational exposure to: fumes solvents chemicals other

Explain: _____

Social History

Marital status Single Married Separated Divorced Widowed

Tobacco

Do you smoke now? yes no

Have you ever? yes no

If yes, what? _____

How much? Number per/day _____

For how long? _____

If no, when did you quit? _____

Do you chew tobacco? yes no

Alcohol/Drugs

Do you drink alcohol? yes no

How many drinks/week _____

Diet

Any special diet yes no _____

Exercise

Do you exercise regularly? yes no

If yes, what kind? _____

Review of Symptoms

Difficulty breathing yes no

Cough yes no

Chest pain/pressure yes no

Rapid heart rate yes no

Irregular heart rate yes no

Swelling in ankles yes no

Easy Bruising/Bleeding yes no

Weakness of arm or leg yes no

Numbness or tingling yes no

Pain in legs when walking yes no

Varicose Veins yes no

Weight loss yes no

Comments: _____

Vein Patients Complete the Following

Have you had any vein procedures? yes no

If yes, what procedure? _____ When? _____

Do you have any of the following?

Aching/pain yes no Leg R L

Heaviness yes no Leg R L

Itching/burning yes no Leg R L

Swelling yes no Leg R L

Cramping yes no Leg R L

Throbbing yes no Leg R L

Ulcers yes no Leg R L

Discoloration yes no Leg R L

Conservative Measures

Have you used any of the following?

Medication? yes no _____

Elevation? yes no _____

Compression hose? yes no

If so, what compression? _____

Length of time worn? _____

