VASCULAR SURGERY QUESTIONAIRE

NAME__________________________________ **AGE:** _____ **D.O.B.** ________________
PRIMARY CARE PHYSICIAN:_______________________________
WHO REFERRED YOU TO US?_______________________________

REASON FOR VISIT (please circle all that apply):

1) Aortic aneurysm yes
2) Carotid artery disease yes
3) Difficulty walking yes
4) Kidney failure/hemodialysis yes
5) Leg swelling yes
6) Nonhealing foot/toe ulcer yes
7) Toe/foot gangrene yes
8) Varicose veins yes
9) Other ____________________________

PAST MEDICAL HISTORY (please circle if yes):

1) Coronary artery disease yes Name of cardiologist? _____________
2) Heart attack yes When? ________________________
3) Stroke/TIA yes When? ________________________
4) High blood pressure yes What is your average Bp? _____/ ___
5) Diabetes mellitus yes How long? ________What type? ___
6) Problems with blood clotting yes Describe: ______________________
7) Clots in veins yes When and where?________________
8) Kidney failure yes Name of kidney doctor?____________
9) Gastrointestinal Disease: yes Specify: ______________________
10) Lung Disease yes Specify: ______________________
11) Thyroid Disease yes Specify: ______________________
12) Elevated cholesterol/lipids yes Specify if known. ________________
13) Smoking yes How much? ____________________
14) Do you drink alcohol? yes How much? ____________________

MEDICATIONS (dosage and frequency):

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.________________________________
7.________________________________
8.________________________________
9.________________________________
10._______________________________

ALLERGIES: ____

PAST SURGICAL PROCEDURES with date: ____________________________________

FAMILY HISTORY

1. Have any of your other relatives (brothers, sisters, or children) had any of the following?

	Mother	Father	Sibling
a) Heart Disease	☐	☐	☐
b) Stroke	☐	☐	☐
c) High Blood Pressure	☐	☐	☐
d) Diabetes	☐	☐	☐
e) Bleeding Disorders	☐	☐	☐
f) Aneurysm	☐	☐	☐
g) Varicose Veins	☐	☐	☐

REVIEW OF SYSTEMS

1. HEAD & EYES

a) Are you troubled by unusual or severe headaches? Yes No
b) Have you ever temporarily lost sight in one eye? Yes No
c) Have you been told that you have glaucoma Yes No

2. RESPIRATORY

a) Do you get short of breath climbing one flight of stairs? Yes No
b) Do you have asthma or wheezing? Yes No
c) Do you have tuberculosis? Yes No
d) Do you have shortness of breath at rest? Yes No
e) Do you have emphysema? Yes No

3. CARDIAC

a) Do you have any known heart disease? Yes No
b) Do you get chest pain? Yes No
c) Do you have to sleep with your head elevated on several pillows because of shortness of breath? Yes No
d) Do you ever wake from sleep with marked shortness of breath? Yes No
e) Do you ever feel your heart racing or pounding for no apparent reason? Yes No

4. GASTROINTESTINAL

a) Do you have frequent heartburn or indigestion? Yes No
b) Do you have any history of stomach or duodenal ulcer? Yes No
c) Have you ever had yellow jaundice or hepatitis? Type: A____ B____ C____Yes No
d) Do you have bright red blood with bowel movements? Yes No

5. GENITOURINARY

a) Do you currently have a bladder or kidney infection? Yes No
b) Do you have difficulty urinating? Yes No
c) Have you recently had any blood in your urine? Yes No
d) Do you awake at night to urinate? Yes No

6. HEMATOLOGIC

a) Are you anemic? Yes No
b) Have you ever had blood transfusions? Yes No
c) Do you bleed readily? Yes No

7. MUSCULOSKELETAL

a) Have you had any fractured or broken bones? Yes No
(If "Yes", please list and give dates.)

____

____

b) Are you troubled by low back pain or back strain? Yes No

c) Is there any history of pain, stiffness, or swelling of joints? Yes No

8) OBSTETRICS AND GYNECOLOGIC *(For females only)*

a) Are you currently pregnant? Yes No
b) What is the date of your last menstrual period?

9) PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU WOULD LIKE ME TO KNOW ABOUT.

Current Venous History

SYMPTOMS (Please check all that apply)

Left	Right		Left	Right	
☐	☐	……….. Aching or Pain	☐	☐	……….. Throbbing
☐	☐	……….. Leg cramps	☐	☐	……….. Itching/Burning
☐	☐	……….. Swelling	☐	☐	……….. Heaviness
☐	☐	……….. Tiredness/Fatigue	☐	☐	……….. Restless Legs

Please indicate the duration of the above symptoms: ☐1-3 months ☐4-6 months ☐6-12months ☐>12months

Have any of the above symptoms resulted in impaired mobility or inability to perform your daily activities? Y/N

Do you wear support hose? Y/N If yes, are they prescription? Y/N
How many years have you been wearing support hose? _________
Do they help reduce symptoms? Y/N
Does standing aggravate your symptoms? Y/N
What helps to decrease your symptoms?____
What makes your symptoms worse? ___________________________________

WOMEN: Do symptoms increase before/during menstruation? Y/N
Are you pregnant or actively trying to get pregnant? Y/N
Are you breast-feeding? Y/N

VENOUS MEDICAL HISTORY Skin Discoloration

History of:

☐ Vein Surgery If yes, year _______ and MD name ___________

☐ Vein Injections If yes, year______and MD name ____________

☐ Vein Laser or RFA Treatment If yes, year ______ and MD name ___ ______

☐ Blood Clots (Phlebitis)? Y / N

☐ Leg Ulcers or Spontaneous Bleeding? Y/N

☐ Skin Discoloration? Y/N

☐ Other Vein Treatment or Leg Injury: _________________________________

☐ Hepatitis ☐ HIV ☐ AIDS

☐ Pregnancies: Number: __________ ☐ Deliveries: Number_______________

Birth Years: ____

What made you decide to seek treatment at this time?___________________________________