Atlanta Heart

VASCULAR SERVICES

Medical History for Vascular Services

Name: _____ Appointment Date: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

What is the reason for today's visit? _____

Have you had any changes in your medication or medical history since your last visit with your Atlanta Heart Associates cardiologist? ☐ Yes ☐ No If yes, please explain:

_____

Have you had any surgeries or hospitalizations since your last visit with your Atlanta Heart Associates cardiologist? ☐ Yes ☐ No If yes, please explain (include the name of hospital):

_____

Occupation (including former): _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

YOUR SYMPTOMS	CHECK (✓) ALL THAT APPLY TO YOU			
	Left Leg	Right Leg	Ankle	Calf
Leg pain often from prolonged sitting or standing				
Swelling				
Tired, heavy feeling in leg				
Varicose Veins				
Spider Veins				
Discoloration of skin				
Open sores or ulcers on lower leg				

When did your symptoms begin? _____

How frequent are your symptoms? Hourly _____ Daily _____ Weekly _____

How would you describe your pain	Check (✓) all that apply to you.		
Aching		Itching	
Burning		Tingling	
Cramping		Numbness	
Stabbing			

DEGREE OF PAIN MEASURED FROM 1 to 10. (1 being minimal; 10 being worst)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Any history of vein problems in the family? ☐ Yes ☐ No If yes, relationship: _____

Any history of blood clots? ☐ Yes ☐ No

Have you ever had varicose vein bleeding? ☐ Yes ☐ No

Have you had leg ulcers? ☐ Yes ☐ No

Have you had previous vein treatment? ☐ Yes ☐ No

If yes, please list what kind of treatment and when: _____

_____

Tried WEARING SUPPORT HOSE? ☐ Yes ☐ No If yes, how long ? _____

Tried FREQUENT ELEVATION? ☐ Yes ☐ No

Tried any MEDICATION (OVER THE COUNTER)? ☐ Yes ☐ No

If yes, which one ? _____

Tried any PRESCRIPTION MEDICATION? ☐ Yes ☐ No

If yes, which one ? _____

Tried WEIGHT REDUCTION? ☐ Yes ☐ No

Tried DAILY WALKING? ☐ Yes ☐ No

Tried to AVOID PROLONG SITTING/STANDING? ☐ Yes ☐ No

Tried LYING STILL? ☐ Yes ☐ No

Does this condition interfere with daily living? ☐ Yes ☐ No

What makes your condition worse? Check (✓) all that apply to you.			
Standing		Bending Over	
Walking		Exertion	
Sitting		Friction from Clothes	
Lifting			

_____ _____

Patient Signature DOB Date Completed

Revised 07/15/2016