Medical History for Vascular Patients

Name_____Date_____

Do you smoke? ☐ YES ☐ NO
Age started_____ Age stopped_____ Cigarettes per day_____
Do you drink alcohol? ☐YES ☐NO Type and Amount_____

	☐ YES	☐ NO	DATE OF ONSET	DESCRIBE
Chest pain/tightness				
Chronic Cough				
Cardiac Disease				
Shortness of Breath				
KidneyDisease				
Heart Mumur				
Palpitations				
High Blood Pressure				
Low Blood Pressure				
Swelling (hands, feet, etc)				
VaricoseVeins				
BloodClots				
Diabetes				

Please list ALL Medications you are presently taking on a regular basis:

MEDICATION	DOSE	HOW OFTEN

Are you allergic to any medications or foods? ☐ YES ☐ NO (if yes, please list below)

_____
_____
_____

ARE YOU:

(1) Allergic to X-Ray Dye? ☐ YES ☐ NO

(2) Do you attend dialysis? ☐ YES ☐ NO

If so, which days? M/W/F T/TH/SAT

Facility location and phone number?_____