ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

Referring Physician: ______________________________________

Current History:

1. Symptom: What specifically brings you to the doctor today?
____
____

2. Duration: When did this problem start? _________________________________

If you are experiencing any pain, how long does it last?_________

3. Location: Where exactly is the pain or problem located, including which side of the body?
____

Left side______ Right side______ both sides______

4. Severity: On a scale of zero to ten(10 being the worst pain), how would you rate your pain? _______________

5. Quality: Describe exactly what the pain feels like (sharp, dull, constant, stabbing, etc...)
____

6. Timing: When exactly does the pain occur (rest, activity, while sleeping, etc.)?
____
____

7. Context: Is this pain related to:

___Activities ___Exercise ___Rest ___Meals

8. Modifying Factors: Does anything seem to help the problem such s rest or medication? ____

9. Associated Signs/Symptoms: Are you having any other problems because of this condition?
____
____

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

PAST MEDICAL HISTORY

ALLERGIES

Are you allergic to any medications (s)?
___ Yes (please list) ___ No

Are you allergic to Latex?
___ Yes ___No Reaction: ________

Medication **Reaction**

1.____
2.____
3.____
4. ____
5. ____
6. ____
7. ____
8. ____

Medications you are currently taking: Include aspirin and over-the-counter medicine.

Drug Name Dose How Often

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10.____

Past Hospitalizations and Operations:

Reason Year

1. ____
2. ____
3. ____
4. ____
5. ____

Do you have any implanted medical devices?

___Pacemaker ___Defibrillator ___Orthopedic hardware/total joints

___Portacath ___Other (please explain): _______________________

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Social history:
Height: ___________________
Current Weight: ____________
Do you smoke? : ____________
If yes pack per day: ____________ for __________ years.
If you smoked in the past, when did you quit? ________________
Do you consume alcohol? ______ How much? _______________ how often? _______
Recreational/street drugs? ______ What type? _______ How often? ________________
Your last flu shot ________ Pneumovax ____________ Tetanus ___________
Do you wear: __________ Glasses _________ Contacts __________ Dentures __________
Hearing aids __________
Do you exercise? __________ What type ? _______ How often? __________

Past Medical History: Do you have a personal history of any of the following?
Heart disease: ____
High Blood pressure: ____
Stroke: ____
Diabetes: ____
Lung disease:____
Kidney disease: ____
Cancer (type): ____
High cholesterol: ____
Other: ____

Family Health History: Please indicate relatives who have or had this disease.
Heart disease: ____
High Blood pressure: ____
Stroke: ____
Diabetes: ____
Bleeding disorders: ____
Kidney disease: ____
Cancer (type): ____
High cholesterol: ____
Other: ____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

Recent weight loss/gain N Y ___________________________________
Fever N Y ____________________________________
Headaches N Y ____________________________________
Fatigue N Y ____________________________________
Night Sweats N Y ____________________________________
Other

____

____

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

INTEGUMENTARY (SKIN)

Rash or itching	N	Y ______________________________
Change in skin color	N	Y ______________________________
Change in hair or nails	N	Y ______________________________

* If yes please explain

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing	N	Y ______________________________
Earaches or drainage	N	Y ______________________________
Chronic sinus problem	N	Y ______________________________
Nose bleeds	N	Y ______________________________
Mouth sores	N	Y ______________________________
Bleeding gums	N	Y ______________________________
Sore throat/voice change	N	Y ______________________________
Swollen glands in neck	N	Y ______________________________
Glaucoma	N	Y ______________________________
Cataract	N	Y ______________________________
Loss Vision	N	Y ______________________________

*If yes explain

RESPIRATORY

Chronic or frequent coughs	N	Y ______________________________
Coughing up blood	N	Y ______________________________
Shortness of breath	N	Y ______________________________
Asthma or wheezing	N	Y ______________________________
Emphysema/COPD	N	Y ______________________________
Use Oxygen at Home	N	Y ______________________________
Sleep Apnea	N	Y ______________________________
Chronic Bronchitis	N	Y ______________________________
Pneumonia	N	Y ______________________________

*If yes please explain

CARDIOVASCULAR

Heart Attack	N	Y ______________________________
Chest pain/Angina	N	Y ______________________________
Cardiac Stents	N	Y ______________________________
Irregular heart beat	N	Y ______________________________
Congestive Heart Failure	N	Y ______________________________
Murmur	N	Y ______________________________
High blood pressure	N	Y ______________________________
Palpitations	N	Y ______________________________
Mitral Valve Prolapse	N	Y ______________________________
Swelling of the feet	N	Y ______________________________

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MEDICAL HISTORY

GASTROINTESTINAl		
Loss of appetite	N	Y ____________
Change in bowel movements	N	Y ____________
Nausea or vomiting	N	Y ____________
Painful bowel movements	N	Y ____________
Constipation	N	Y ____________
Diarrhea	N	Y ____________
Rectal bleeding/blood in stool	N	Y ____________
Abdominal Pain	N	Y ____________
Peptic Ulcer (stomach)	N	Y ____________
Heartburn/Acid Reflux	N	Y ____________
Gallbladder problems	N	Y ____________
Colon Polyps	N	Y ____________
Date of Last Colonoscopy	N	Y Date ____________
Last Upper Endoscopy	N	Y____________
GENITOURINARY		
Frequent Urination	N	Y ____________
Burning or painful urination	N	Y ____________
Blood in Urine	N	Y ____________
Change in force/strain to urinate	N	Y ____________
Incontinence	N	Y ____________
Kidney Stones	N	Y ____________
Male-testicular pain	N	Y ____________
Female- last menstrual period	N	Y ____________
Enlarged Prostate	N	Y ____________
Prostate Cancer	N	Y ____________
MUSCULOSKELETAL		
Difficulty walking	N	Y ________After how many blocks ______
Cramps in calves or thighs walking	N	Y ____________
Pain that wakes you from sleep	N	Y ____________
Joint stiffness or swelling	N	Y ____________
Weakness of muscles or joints	N	Y ____________
Cold extremities	N	Y ____________
Numbness/Tingling of legs	N	Y ____________
Numbness/Tingling of arms	N	Y ____________
NEUROLOGIC		
Stroke	N	Y ____________
Mini Strokes/TIA's	N	Y ____________
Paralysis	N	Y ____________
Tremors	N	Y ____________
Seizures	N	Y ____________
Loss of Memory or Dementia	N	Y ____________
Headaches	N	Y ____________
Dizziness	N	Y ____________

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PSYCHIATRIC

Depression	N	Y ______________________
Anxiety	N	Y ______________________
Panic Attacks	N	Y ______________________

ENDOCRINE

Diabetes	N	Y ______________________
Insulin	N	Y ______________________
Oral meds only	N	Y ______________________
Thyroid Disease	N	Y ______________________
Cold Intolerance	N	Y ______________________
Heat Intolerance	N	Y ______________________

HEMATOLOGIC

Bleeding Tendency	N	Y ______________________
Taking Blood Thinners	N	Y __________Type __________

Reason ____

Clotting Problems	N	Y ______________________
Anemia	N	Y ______________________
Phlebitis	N	Y ______________________

Have you had any recent testing (within the last 6 months)?

Type When Where

Blood Work: ____
EKG: ____
Echocardiogram (heart ultrasound) : ______________________________
X-rays/CT scans:
____
MRI or MRA: ____
Carotid (neck) Doppler/ultrasound: ______________________________
Leg Doppler/ultrasound: ______________________________________

ST. LOUIS VASCULAR CENTER/WEST COUNTY SURGICAL
MEDICAL HISTORY

PATIENT'S FULL NAME ____ M/F_____
Last First Middle
ADDRESS ____Apt# _____________

CITY__________________________________ STATE __________ ZIP_____________

HOME PHONE (   )___________________________CELL # ___________________________
DATE OF BIRTH_____________________ AGE_________ EMAIL :________________________

<u>RACE</u>: BLACK / WHITE / AMERICAN INDIAN / ASIAN OR PACIFIC ISLANDER

<u>ETHNICITY</u>: HISPANIC / NON HISPANIC

<u>LANGUAGE:</u> ENGLISH / SPANISH / CHINESE / FRENCH / GERMAN / JAPANESE / RUSSIAN

SOCIAL SEC. #________________________

EMPLOYER _________________________________ ADDRESS _______________________________

WORK PHONE _______________ EXT. _______ MARITAL STATUS M__S__W__D__

SPOUSE'S NAME__________________ DATE OF BIRTH ______________ AGE _________

EMPLOYER _____________________________ ADDRESS __________________________________

SPOUSE'S SOC. SEC. # ______________________ WORK PHONE _________________________
CELL # _____________________
IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S NAME _____________________________
ADDRESS______________________________ PHONE ____________________________________
EMPLOYER'S ADDRESS ____

INSURANCE INFORMATION
Company Policy# Group# Insured
1.____

2.____
WHOM MAY WE CONTACT IN CASE OF EMERGENCY?______________________________
Relationship ________________________________ Phone #.__________________________________

Is this visit due to an injury? Y/N Is this a work-related injury? Y/N If yes date of injury ____________
____

WHOM MAY WE THANK FOR REFFERRING YOU TO US? _____________________________
I hereby authorize my insurance company to pay all benefits directly to West County Surgical Specialists, Inc. I understand that execution of this assignment in no way relieves me of my financial responsibility, and any unpaid claims resulting in collection procedures may have fees assessed with them.

DATE: _________________ SIGNATURE: ____
I authorize West County Surgical Specialists, Inc. to release medical information pertaining to the patient's treatment to my insurance company, and/or attorney, and/ or Workmen's Compensation carrier as needed to process claims.
In addition I wish to authorize the following person ____________________ relationship ______________________
To discuss information regarding my condition and medical information.

DATE: _________________ SIGNATURE: ____