**VASCULAR AND ENDOVASCULAR INSTITUTE OF ORANGE COUNTY** A MEDICAL CORPORATION
Gary Nishanian MD, RVT, FACS 26800 Crown Valley Parkway, Suite 420, Mission Viejo, CA 92691

# MEDICAL QUESTIONAIRE - FOLLOWUP VISIT

Patient Name: _____ Date: ____/____/_____

WHAT VASCULAR PROBLEMS ARE WE ADDRESSING TODAY:

_____

## Medical History

Did you have or develop any of the following medical problems **DURING THE PAST YEAR**?

| MEDICAL PROBLEMS | YES | NO |
|---|---|---|
| Aneurysms | ☐ | ○ |
| Carotid blockage | ☐ | ○ |
| Stroke or TIAs | ☐ | ○ |
| Deep Vein Thrombosis | ☐ | ○ |
| Leg wounds | ☐ | ○ |
| Leg swelling | ☐ | ○ |
| Varicose veins | ☐ | ○ |
| Need to use a walker | ☐ | ○ |

| MEDICAL PROBLEMS | YES | NO |
|---|---|---|
| Heart Failure | ☐ | ○ |
| Heart Attack | ☐ | ○ |
| Kidney failure or dialysis | ☐ | ○ |
| Infections (including dental infections) | ☐ | ○ |
| Cancer (Malignancy) | ☐ | ○ |
| Diabetes | ☐ | ○ |
| High Blood Pressure | ☐ | ○ |
| High Cholesterol | ☐ | ○ |

## Surgical History

Please list any surgical procedures, radiologic interventions or major trauma **SINCE YOUR LAST VISIT**:

| PROCEDURE | DATE |
|---|---|
| | |
| | |
| | |

## Allergies

Do you have any allergies? Please indicate:

| | WHAT ARE YOU ALLERGIC TO | TYPE OF REACTION |
|---|---|---|
| Medications | | |
| | | |
| | | |
| X-ray dye | | |

## Present Medications

| **Medication** | **Dose** | **Frequency** (how often you take the medicine) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Social History

Tobacco Use: Did you start or quit smoking since your last visit: _____
How many cigarettes do you smoke per day: _____

Alcohol Use: _____ Average number of drinks per week: _____

Reviewed w/ patient ___/___/____ _____

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**PATIENT NAME:**_____ **DATE:**_____

# REVIEW OF SYSTEMS - FOLLOWUP

**HAVE YOU HAD ANY OF THESE SYMPTOMS OVER THE PAST 12 MONTHS - MARK YES OR NO FOR ALL YOUR ANSWERS**

| SYMPTOMS | Yes | No | COMMENTS |
|---|---|---|---|
| **CONSTITUTIONAL** | | | |
| Good general health past year | ☐ | ○ | |
| Weight changes (over 10 lbs) | ☐ | ○ | How much weight_____ |
| Infections (including Dental) | ☐ | ○ | |
| **EYES** | | | |
| Blindness | ☐ | ○ | |
| Temporary blindness in one eye | ☐ | ○ | |
| Blurred or double vision | ☐ | ○ | |
| Eye surgery | ☐ | ○ | What type _____ |
| **EAR/NOSE/MOUTH/THROAT** | | | |
| Ringing in the ear | ☐ | ○ | What side _____ |
| Hoarseness | ☐ | ○ | |
| **SKIN (INTEGUMENTARY)** | | | |
| Serious burns | ☐ | ○ | |
| Non-healing wounds | ☐ | ○ | Location _____ |
| Cosmetic surgery | ☐ | ○ | What type _____ |
| **RESPIRATORY** | | | |
| Emphysema | ☐ | ○ | |
| Shortness of breath | ☐ | ○ | |
| Coughing up blood | ☐ | ○ | |
| Bronchitis or pneumonia | ☐ | ○ | |
| **CARDIOVASCULAR** | | | |
| High blood pressure | ☐ | ○ | |
| High Cholesterol | ☐ | ○ | |
| Shortness of breath | ☐ | ○ | |
| Swelling of feet, ankles or hands | ☐ | ○ | |
| Heart attack | ☐ | ○ | |
| Chest pain or angina | ☐ | ○ | |
| Heart surgery | ☐ | ○ | |
| Can you walk more than one block without stopping? | ☐ | ○ | |
| Problems with heart valves | ☐ | ○ | |
| Palpitations or arrhythmia | ☐ | ○ | |
| Blood clots in the heart | ☐ | ○ | |
| Aneurysms | ☐ | ○ | |
| Varicose veins | ☐ | ○ | |
| **ENDOCRINE** | | | |
| Diabetes | ☐ | ○ | |
| Do you take Insulin? | ☐ | ○ | |
| Overactive thyroid | ☐ | ○ | |
| Any medication past 3 months? | ☐ | ○ | |
| **HEMATOLOGIC** | | | |
| Bleeding disorder | ☐ | ○ | |
| Deep vein thrombosis (DVT) | ☐ | ○ | |
| Blood clots in legs arms or lungs | ☐ | ○ | |
| Reactions to blood thinners | ☐ | ○ | |

| SYMPTOMS | Yes | No | COMMENTS |
|---|---|---|---|
| **GASTROINTESTINAL** | | | |
| Abdominal pain | ☐ | ○ | |
| Abdominal pain after eating | ☐ | ○ | Any weight loss _____ |
| Ulcers | ☐ | ○ | |
| Vomiting blood | ☐ | ○ | |
| Black or bloody stools | ☐ | ○ | |
| Change in bowel habits | ☐ | ○ | |
| Rectal bleeding | ☐ | ○ | |
| Bowel obstruction | ☐ | ○ | |
| Gall bladder attacks | ☐ | ○ | |
| Liver disease | ☐ | ○ | |
| Jaundice | ☐ | ○ | |
| Hepatitis | ☐ | ○ | |
| Pancreatitis | ☐ | ○ | |
| **GENITOURINARY** | | | |
| Renal insufficiency | ☐ | ○ | |
| Renal failure | ☐ | ○ | Since when _____ |
| Dialysis Treatments | ☐ | ○ | |
| **MUSCULOSKELETAL** | | | |
| Muscle pain or cramping | ☐ | ○ | |
| Restless legs | ☐ | ○ | |
| Back pain | ☐ | ○ | |
| Difficulty walking | ☐ | ○ | |
| Broken Bones | ☐ | ○ | |
| **NEUROLOGIC** | | | |
| Stroke | ☐ | ○ | |
| Transient ischemic attack (TIA) | ☐ | ○ | |
| Numbness, tingling, burning | ☐ | ○ | Side / Location _____ |
| Weakness or paralysis | ☐ | ○ | Side / Location _____ |
| Seizure | ☐ | ○ | |
| Memory loss | ☐ | ○ | |
| **RHEUMATOLOGIC** | | | |
| Rheumatoid arthritis | ☐ | ○ | |
| Lupus | ☐ | ○ | |
| Scleroderma | ☐ | ○ | |
| Vasculitis | ☐ | ○ | |
| Polymyalgia rheumatica | ☐ | ○ | |
| **WOMEN'S HEALTH** | | | |
| Are you pregnant | ☐ | ○ | |
| Do you take hormonal medications | ☐ | ○ | |
| Do you take contraceptive pills | ☐ | ○ | |
| Do you smoke | ☐ | ○ | |
| Breast Cancer | ☐ | ○ | |
| How long ago and where | ☐ | ○ | |
| Breast Surgery | ☐ | ○ | |
| How long ago and where | ☐ | ○ | |
| **PSYCHIATRIC** | | | |
| Claustrophobia | ☐ | ○ | |
| Psychiatric medication past 3 months | ☐ | ○ | |

| DO YOU HAVE ANY OF THESE CONDITIONS | | | | | | |
|---|---|---|---|---|---|---|
| Fibromyalgia | ☐ | ○ | | Marfan's disease | ☐ | ○ |
| Raynaud's disease | ☐ | ○ | | Chronic Fatigue Syndrome | ☐ | ○ |

Reviewed w/ patient ___/___/____ _____