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 - INITIAL VISIT

Date: ____/____/_____

Patient Name: ____ Birth Date: ____/____/_____

Your answers on this form are confidential and will help your doctor understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it and indicate that you declined to give an answer.

WHAT IS THE MAIN REASON YOU ARE SEEING A VASCULAR SURGEON TODAY:

____

____

ARE THERE ANY OTHER VASCULAR ISSUES YOU WOULD LIKE TO HAVE ADDRESSED:

____

Past Medical History

Please indicate whether you have had any of the following medical problems.

MEDICAL PROBLEMS	YES	NO	COMMENTS
Emphysema	☐	○	
COPD or Lung Disease	☐	○	
Heart Disease:	☐	○	
Specify Type			
Stroke	☐	○	
Heart Attack	☐	○	
High Blood Pressure	☐	○	
Diabetes	☐	○	
How many years			
Do you take Insulin	☐	○	
High Cholesterol	☐	○	
Emphysema	☐	○	
Renal Failure or Dialysis	☐	○	
Thyroid Problem	☐	○	
Bleeding or Bruising Problem	☐	○	
Blood Clots / “Thick Blood”	☐	○	
Blood Transfusions	☐	○	
Cancer (Malignancy)	☐	○	
Specify Type			
Depression / Suicide Attempt	☐	○	
Alcoholism	☐	○	
Smoking	☐	○	
ANESTHESIA PROBLEMS	☐	○	
RECENT INFECTIONS (including dental infections)	☐	○	
DO YOU USE A WALKER	☐	○	
DO YOU USE A WHEELCHAIR OR A SCOOTER	☐	○	
OTHER PROBLEMS: (specify)	☐	○	

Reviewed w/ patient ___/___/____ _______

Past Surgical History

Please list other previous **surgica**l procedures, **radiologic** interventions or **major traumatic** injuries:

PROCEDURE	DATE

Allergies

Do you have any allergies? Please indicate:

	WHAT ARE YOU ALLERGIC TO	TYPE OF REACTION
Medications		
Environmental		
Chemical		
Latex		
Betadine		
Iodine		
Shellfish		
Intravenous contrast / X-ray dye		
Tape		

Medications That You Take

List all current medications you are taking and their dosages. Prescriptions, hormone replacement therapy, vitamins, herbs, and all over the counter drugs should be included

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

Reviewed w/ patient ___/___/____ _______

Family History

Do any of your **close blood-related relatives** have problems with:

RELATIVE'S MEDICAL CONDITION	YES	NO	AFFECTED RELATIVE
Relatives with Anesthesia problems		○	
Relatives with Bleeding disorders		○	
Relatives with Heart Disease		○	
Relatives with Diabetes		○	
Relatives with High blood pressure		○	
Relatives with Stroke		○	
Relatives with Aneurysms		○	
Relatives with Vascular Disease		○	
Relatives with Gangrene		○	
Relatives with Varicose veins		○	
Relatives with Blood clots		○	
Relatives with Seizures or Migraines		○	

Social History

Marital Status ___________________ Number of Children: _____________ Ages: _____________

Education level completed ____

Current or Last Occupation ___________________ Current Employment Status ___________________

Last Employer ____

Tobacco Use:

Cigarettes:
How many cigarettes do you or did you smoke per day: ______ How many years of smoking: _______

When did you smoke your last cigarette: ____

Do you smoke a Pipe, Cigars, or Chew Tobacco: __________ Specify: _______________________

Alcohol Use: ____________________ Average number of drinks per month: _______________________

Drug Use: ____________________

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REVIEW OF SYSTEMS - INITIAL

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS - 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_______
			Over how long _________
Recurrent fevers, chills, sweats	☐	○	
Major infections (including dental)	☐	○	
Chronic fatigue	☐	○	
Pain score 1-10(10 is worst)	☐	○	
EYES			
Blindness	☐	○	
Wear glasses/contact lenses	☐	○	
Temporary blindness in one eye	☐	○	
Blurred or double vision	☐	○	
Cataracts	☐	○	
Glaucoma	☐	○	
Eye surgery	☐	○	What type _____________
EAR/NOSE/MOUTH/THROAT			
Difficulty hearing	☐	○	
Ringing in the ear	☐	○	What side ____________
Vertigo	☐	○	
Chronic sinus problems	☐	○	
Mouth sores	☐	○	
Bleeding gums	☐	○	
Frequent sore throats	☐	○	
Hoarseness	☐	○	
Snoring	☐	○	
SKIN (INTEGUMENTARY)			
Rash	☐	○	
Birthmark	☐	○	
Scarring	☐	○	
Serious burns	☐	○	
Non-healing wounds	☐	○	Location ______________
History of skin cancer	☐	○	
New skin growth or mole	☐	○	
Cosmetic surgery	☐	○	What type ______________
RESPIRATORY			
Emphysema	☐	○	
Asthma or wheezing	☐	○	
Shortness of breath	☐	○	
Chronic cough	☐	○	
Coughing up blood	☐	○	
Bronchitis or pneumonia	☐	○	
CARDIOVASCULAR			
High blood pressure	☐	○	
High Cholesterol	☐	○	
Shortness of breath	☐	○	
Do you sleep on 3 or more pillows	☐	○	
Do you sleep in a recliner at night	☐	○	
Swelling of feet, ankles or hands	☐	○	
Previous heart attack	☐	○	
Chest pain or angina	☐	○	
Heart surgery	☐	○	
Can you walk more than one block without stopping?	☐	○	
Murmur	☐	○	
Problems with heart valves	☐	○	
Palpitations or arrhythmia	☐	○	
Blood clots in the heart	☐	○	
Aneurysms	☐	○	
Varicose veins	☐	○	

SYMPTOMS	Yes	No	COMMENTS
GASTROINTESTINAL			
Abdominal pain	☐	○	
Abdominal pain after eating	☐	○	Any weight loss ____
Nausea	☐	○	
Vomiting	☐	○	
Heartburn/Reflux	☐	○	
Change in appetite	☐	○	
Ulcer	☐	○	
Vomiting blood	☐	○	
Black or bloody stools	☐	○	
Diarrhea	☐	○	
Constipation	☐	○	
Change in bowel habits	☐	○	
Rectal bleeding	☐	○	
Hemorrhoids	☐	○	
Bowel obstruction	☐	○	
Gall bladder attacks	☐	○	
Liver disease	☐	○	
Jaundice	☐	○	
Hepatitis	☐	○	
Pancreatitis	☐	○	
GENITOURINARY			
Renal insufficiency	☐	○	When and what type?
Renal failure	☐	○	
Dialysis Treatments	☐	○	
Difficulty urinating	☐	○	
Decreased force of stream	☐	○	
Blood in the urine	☐	○	
Burning with urination	☐	○	
Urinary tract infection	☐	○	
Kidney stones	☐	○	
Sexually transmitted disease	☐	○	
Syphilis	☐	○	
Change in sexual function or interest	☐	○	
MUSCULOSKELETAL			
Joint stiffness or pain	☐	○	
Muscle pain or cramping	☐	○	
Restless legs	☐	○	
Weakness of muscles or joints	☐	○	
Back pain	☐	○	
Difficulty walking	☐	○	
Arthritis (osteo, rheumatoid)	☐	○	
Broken Bones	☐	○	
NEUROLOGIC			
Stroke	☐	○	
Transient ischemic attack (TIA)	☐	○	
Numbness, tingling, burning	☐	○	Side / Location _______
Weakness or paralysis	☐	○	Side / Location _______
Headache	☐	○	
Migraine	☐	○	
Seizure	☐	○	
Memory loss	☐	○	
Family history of Alzheimer's Disease	☐	○	
RHEUMATOLOGIC			
Rheumatoid arthritis	☐	○	
Lupus	☐	○	
Scleroderma	☐	○	
Vasculitis	☐	○	
Polymyalgia rheumatica	☐	○	

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REVIEW OF SYSTEMS - INITIAL

PLEASE CLEARLY MARK **YES** OR **NO** FOR ALL YOUR ANSWERS

SYMPTOMS	Yes	No	COMMENTS	SYMPTOMS	Yes	No	COMMENTS
ENDOCRINE				**WOMEN'S HEALTH**			
Heat or cold intolerance	□	○		Are you pregnant	□	○	
Excess thirst	□	○		Do you take hormonal medications	□	○	
Excessive amount of urination	□	○		Do you take contraceptive pills	□	○	
Diabetes	□	○		Do you smoke	□	○	
Do you take Insulin?	□	○		Fibrocystic breasts	□	○	
Overactive thyroid	□	○		Breast Cancer	□	○	
Any medication past 3 months?	□	○		How long ago and where	□	○	
Parathyroid problems	□	○		Breast Surgery	□	○	
Any medication past 3 months?	□	○		How long ago and where	□	○	
Calciphylaxis	□	○		Ovarian cysts	□	○	
				Endometriosis	□	○	
HEMATOLOGIC				Abnormal uterine bleeding	□	○	
Easy bruising	□	○		Fibroids of the uterus	□	○	
Difficulty stopping bleeding	□	○					
Bleeding disorder	□	○		**PSYCHIATRIC**			
Prior deep vein thrombosis (DVT)	□	○		Claustrophobia	□	○	
Blood clots in legs or arms	□	○		Depression	□	○	
Blood clots in the lungs	□	○		Any medication past 3 months?	□	○	
Enlarged lymph nodes	□	○		Schizophrenia	□	○	
Transfusion	□	○		Any medication past 3 months?	□	○	
Reactions to blood thinners	□	○		Mood swings/irritability	□	○	
				Any medication past 3 months?	□	○	

DO YOU HAVE ANY OF THESE CONDITIONS

Condition	Yes	No	Comments	Condition	Yes	No	Comments
Fibromyalgia	□	○		Marfan's disease	□	○	
Familial Mediterranean Fever (FMF)	□	○		Ehlers-Danlos syndrome	□	○	
Raynaud's disease	□	○		Down's syndrome	□	○	
Addison's disease	□	○		Chronic Fatigue Syndrome	□	○	

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PATIENT INFORMATION:

DATE: ______________________

NAME: ____ ADDRESS: ____

AGE: ______ BIRTH DATE: ________________ CITY: ________________________ STATE: ______

SEX: M F MARITAL STATUS: M S W D ZIP: ____________

HOME PHONE #: ______________________________ CELL #: ____

SOCIAL SECURITY #: ___________________________ DRIVERS LICENSE #: ___________________________

EMPLOYER: __________________________________ WORK PHONE #: ______________________________

Relative not living with you: ________________________ Relative's Phone #: ______________________________

WHO REFERRED YOU TO OUR OFFICE: ____

WHO IS YOUR PRIMARY CARE PHYSICIAN: ______________________________ PHONE #: ____________________

RESPONSIBLE / INSURED PARTY INFORMATION: --- IF DIFFERENT FROM PATIENT

NAME: ____ ADDRESS: ____

RELATIONSHIP TO PATIENT: ___________________ CITY: _____________________ STATE: ____________

ZIP: ______________

HOME PHONE#: _______________________________ CELL #: ____

EMPLOYER: _________________________________ WORK PHONE #: ______________________________

SOCIAL SECURITY #: ___________________________ DRIVER'S LICENSE #: __________________________

DATE OF INJURY: _______ WORK RELATED? Y N AUTO? Y N OTHER? ______________________

INSURANCE INFORMATION MUST BE WRITTEN BELOW

PRIMARY INSURANCE: _____________________ ID #: ___________________ GROUP #: ____________________

ADDRESS: ________________________________ CITY: __________________ STATE: _____ ZIP: ____________

PHONE #: _______________________ SECONDARY INSURANCE: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Vascular Endovascular Institute of Orange County to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above named patient by Vascular and Endovascular Institute of Orange County and/or Dr. Gary Nishanian. I assign any benefits payable by the insurance carriers for those services to Vascular and Endovascular Institute of Orange County and/or Dr. Gary Nishanian. ***I agree to be responsible for any amount and/or supplies not covered by insurance or for the full amount if the above named patient does not have insurance.***

DATE: ______________________ SIGNATURE: ____