UVA UNIVERSITY VASCULAR ASSOCIATES

MEDICAL HISTORY FORM

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ______________

Past Medical History *(circle answer)*:

Description			Year of Onset
Hypertension	Yes	No	
Coronary Artery Disease	Yes	No	
Stroke	Yes	No	
Diabetes	Yes	No	

Description			Year of Onset
Chronic Renal Failure	Yes	No	
High Cholesterol	Yes	No	
Obesity	Yes	No	
COPD (Chronic Obstructive Pulmonary Disease)	Yes	No	

Other: ______________________________

Surgical History
Please list all previous operations:

Surgery Type	Date	Doctor/Hospital

Allergies ☐ Yes ☐ No ______________________________

Medications ☐ Yes ☐ No
If yes, please list below

Medication Name	Direction

Medication Name	Direction

Family History: Have any of your blood relatives ever had (*circle answer*):

Description			Family Member
Cancer	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Heart Trouble	Yes	No	
High Blood Pressure	Yes	No	
Stroke	Yes	No	
Mental Illness	Yes	No	
Bleeding Tendency	Yes	No	
Gout	Yes	No	
Arthritis at an Early Age	Yes	No	
Hereditary Defects	Yes	No	

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Social History

Smoking:	☐ Yes	☐ No	If yes, how many packs per day? ______________ Quit: how long ago? ___________
Alcohol Use:	☐ Yes	☐ No	If yes, how much per week?____
Caffeine:	☐ Yes	☐ No	If yes, how many per day? ____
Employment:	☐ Yes	☐ No	If yes, what is your occupation? ____

Systemic Review

Do you have any of the following?

General:		
Fevers	Yes	No
Night sweats	Yes	No
Chills	Yes	No
Recent weight change	Yes	No
Skin:		
Hives	Yes	No
Eczema	Yes	No
Rash	Yes	No
Abnormal pigmentation	Yes	No
Heads-Eyes-Ears-Nose-Threat:		
Eye disease or injury	Yes	No
Do you wear glasses?	Yes	No
Change in vision	Yes	No
Change in hearing	Yes	No
Frequent sneezing	Yes	No
Nosebleeds	Yes	No
Respiratory:		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Cardiovascular:		
Chest pain or palpitations	Yes	No
Shortness of breath while walking or lying down	Yes	No
Difficulty walking two blocks	Yes	No
Swelling of hands, feet, or ankles	Yes	No
Heart murmur	Yes	No
Gastrointestinal:		
Peptic ulcer (stomach or duodenal)	Yes	No
Bleeding with bowel movements	Yes	No
Black stools	Yes	No
Recent change in bowel habits	Yes	No
Frequent diarrhea	Yes	No
Heartburn or indigestion	Yes	No

Genitourinary:		
Frequent urination	Yes	No
Nighttime urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Kidney stones	Yes	No
Musculoskeletal:		
Joint pain	Yes	No
Joint swelling	Yes	No
Injuries to joint	Yes	No
Fractures	Yes	No
Psychiatric:		
Depression	Yes	No
Change in vision	Yes	No
Anxiety	Yes	No
Hallucinations	Yes	No
Paranoia	Yes	No
Are you comfortable w/ your weight	Yes	No
Neurological:		
Fainting spells	Yes	No
Convulsions	Yes	No
Paralysis	Yes	No
Headaches	Yes	No
Hematologic:		
Anemia	Yes	No
Difficulty w/ excessive bleeding?	Yes	No
Abnormal bruising or bleedings?	Yes	No
Swollen glands?	Yes	No
Endocrine:		
Excessive thirst	Yes	No
Urinate frequently	Yes	No
Intolerance to heat/cold	Yes	No
Immunology/Allergy:	Yes	No
Itchy eyes	Yes	No
Runny nose	Yes	No

Gynecological:

Age period first started __________ How long do your periods last? ________________ Frequency of periods ________________

Any pain with periods? ☐ Yes ☐ No Date of first day of last period ___________________

Number of pregnancies _________________ Number of miscarriages _________________

Number of children ____________________ Ages ________________________________

I understand that the above information is required to provide me with the proper medical care in a safe and effective manner. I have completed the questions to the best of my knowledge. Should further information be needed, I give my consent to ask the respective healthcare provider agency to release any necessary information. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: ____ ***Date:*** ________________

PHYSICIAN SIGNATURE: ____ ***DATE:*** ________________