J. Timothy Fulenwider, MD, FACS
Thomas A. Abbruzzese, MD, FACS
J. Clifton Hastings, MD, FACS

Northeast Georgia
PHYSICIANS GROUP
Surgical Associates Vascular Center

PATIENT HEALTH INVENTORY & HISTORY

Today's Date: _______________

Patient Name: _________________________________ __ **Date of Birth:** _____________ **Patient Age:** ________

Referring Physician: _____________________________ **Primary Care Physician:** _______________________________

Reason for today's visit? ____

Symptom's bothering you today? ____

Local Pharmacy Name:___________________________________ **Pharmacy Address:** ___________________________________

Please list any previous illness, hospitalizations or surgeries, and the year.

Description of Illness/ Hospitalization/ Surgery	Year	Description of Illness/ Hospitalization/ Surgery	Year

Please circle if it applies to you:

General History: Weight Gain- Weight Loss- Increased Fatigue- Trouble Sleeping-

Eyesight: Good- Fair- Poor- Glaucoma

Ears, Nose, Throat: Deaf- Poor hearing- Sore Throat- Hoarseness- Sinus Problems

Gastroinestinal: Swallowing Problems- Indigestion- Ulcers- Heart burn- Regurgitation- Abdominal Pain- Rectal Bleeding- Constipation- Diarrhea-

Genitourinary: Difficulting urinating- Blood in urine- Kidney Problems- Kidney Stones- Chronic Kidney Disease-

Musculosketetal: Muscle Weakness- Muscle pain- Joint Pain- Arthritis-

Integumentary: Skin rash- Skin disorders-

Neurological/Psychiatry: Numbness- Seizures- Memory Loss- Fainting- Depression- Anxiety- Drug Dependence-

Endocrine: Thyroid Disease- Excessive thirst or urination- Heat or cold intolerance-

Diabetes: Type 1 Type2 - Do you take Metformin? Yes No

Hematologic/ Lymphatic Taking blood thinners- Taking aspirin- Coumadin- Plavix- Blood clots- Pulmonary Embolism- Anemia- Phlebitis- Past transfusion- Enlarged glands-

Heart/ Vascular: Chest pains- Palpitations- Swollen Feet- Aneurysm- Heart Attack- High Blood Pressure- High Cholesterol- Cardiac Cath? When____________Cardiac Stress Test? When_____________ Temporary Blindness- Mini-strokes- TIA-

Cancer: Colon- Lung- Breast-

Other problems not listed: ____

Patient Name: ___________________________ DOB: __/___/____

Allergies Do you have allergies to drugs, food, latex, dye? YES NO

Allergy- list medication, food, latex, dye, etc.	Reaction- rash, shortness of breath, hives, itching, etc.

Please list medications you are currently taking:

Medication (include over-the-counter & vitamins)	Dose?	How Often?

FAMILY HISTORY

	Living	Deceased	Age	Age at Death	Health Status	Cause of Death
Father						
Mother						
Sister(s)						
Brother(s)						

Do you have a family history of (circle all that apply)?

Diabetes High Cholesterol Stroke Cancer Heart Attack Abdominal Aneurysm

SOCIAL HISTORY

Are you: Married Single Divorced Widowed

Number of children: _________________ Ages__________________

Do you smoke? YES NO How much_____________________ How long__________________

Have you ever smoked? YES NO How much?___________________ How long__________________ Year Quit___________

Do you drink alcohol? YES NO How much per week?_______________________

Do you exercise? YES NO What do you do?_______________________________________ Frequency__________________

Patient Name: __________________________ DOB: __/___/____

*Please answer the questions in the following sections, if they apply to you.

Peripheral Arterial Disease

1. When you walk or exercise, do you experience discomfort (aching, cramping or pain) YES/ NO
   If you answered yes, does the discomfort subside with rest? YES/ NO
2. Have you ever had surgery, balloon procedures, or stents to any blood vessels other than your heart? YES/ NO
3. Do you have painful sores or ulcers on your legs or feet that are not healing? YES/ NO
4. Are your toes or feet pale, discolored, or bluish? YES/ NO
5. Have you ever been told by a physician that you have poor circulation? YES/ NO
6. Do you have leg or ankle swelling? YES/ NO

Chronic Kidney Disease

1. Who is your nephrologist? _______________________________________
2. Are you currently on dialysis? YES/ NO
   If you answered yes, what is the name of your dialysis center ____
   Address: ____Phone number: ______________________________

Shortness of Breath:

Do you have shortness of breath? YES/ NO If yes, answer questions 1-8, If no, move to the next section.

1. How long have you had shortness of breath?____
2. What makes you short of breath? ____
3. Do you wake up at night short of breath? NEVER, RARELY, EVERY NIGHT (circle one)
4. Do you get up to urinate at night? YES/ NO
5. Do you tire easily? YES/ NO
7. Do you have wheezing? YES/ NO
8. Do you have a cough? YES/ NO

Varicose Veins:

1. Do you experience PAIN, SWELLING, THROBBING, CRAMPING (circle all that apply)?
2. Do you wear compression stockings? YES/ NO
   If you answered yes, what is the mmHg compression? 8-15mmHg 20-30mmHg 30-40mmHg
   If you answered yes, how long have you worn compression stockings? 6 weeks 3 months 6 months >6 months
3. Do you have a history of deep vein thrombosis (DVT) or superficial thrombophlebitis (SVT)? YES/ NO
4. Do your daily activities require prolonged periods of sitting or standing? YES/ NO
5. Do you have a history of vein stripping, bleeding or endovenous thermal ablation (RFA/EVLT)? (circle all that apply)

PATIENT SIGNATURE: ____ DATE: ________________

ADVANCED PRACTITIONER SIGNATURE: ________________________________ DATE: _________________

PHYSICIAN SIGNATURE: ____ DATE: _________________