

# Arizona Vein and Vascular Center Patient History Form

Note: This is a confidential record and will be kept in this office. Information contained will not be released to anyone without your authorization.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_ Referring Phycisian: \_\_\_\_\_

Primary Care Phycisian: \_\_\_\_\_ Phone number: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

What health concern has brought you to our office today? \_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Past Medical History (circle yes or no)**

Diabetes	yes	no	CHF	yes	no
High Blood Pressure	yes	no	Arthritis	yes	no
Heart condition	yes	no	Chronic Pain	yes	no
Heart attack	yes	no	Cancer	yes	no
Stroke	yes	no	Heart Arrythmias	yes	no
Thyroid problems	yes	no	Other:	yes	no

If yes please explain: \_\_\_\_\_

**Social History**

Do you smoke? \_\_\_\_\_  
Ever Smoked? \_\_\_\_\_  
Drink Alcohol? \_\_\_\_\_  
Use drugs? \_\_\_\_\_

Packs per day? \_\_\_\_\_  
How many years? \_\_\_\_\_  
How much, if so? \_\_\_\_\_  
How much, if so? \_\_\_\_\_

Recent Testing?	Date
EKG	
CT scan	
Ultrasounds	

Where? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had or do you have:**

varicose veins?	
blood clots?	
stents?	
angioplasty?	

bypass?
deep vein thrombosis?
poor circulation?
other: please explain below

Surgical History:	Dates:

Surgical History:	Dates:

