HORIZON VASCULAR SPECIALISTS
HEALTH INVENTORY AND HISTORY

PATIENT NAME: _____ TODAY'S DATE: _____

SYMPTOMS BOTHERING YOU TODAY: _____

PLEASE LIST ALL ALLERGIES (food/environmental/drug): _____

_____

HEALTH OF PARENTS/SIBLINGS	MAJOR HEALTH PROBLEMS	IF DECEASED: CAUSE & AGE

PATIENT MEDICAL HISTORY		
Circulation Issues	YES	NO
Heart Disease		
Heart Attack *(when?)*		
High Blood Pressure *(how treated?)*		
High Cholesterol *(how treated?)*		
Pacemaker/Defibrillator		
Carotid Artery Problems		
Aneurysm *(Where?)*		
Blood Clots *(where?)*		
Leg Pain at rest		
Leg Pain when walking *(how far?)*		
Vein Issues		
Varicose Veins		
Spider Veins		
Swelling *(where?)*		
Cardiologist:		
Neurological Issues	YES	NO
Stroke		
Mini Stroke (TIA)		
Numbness (hands, feet, legs, other)		
Temporary Vision Loss		
Sudden weakness in arms or legs		
Difficult to speak and/or find your words		
Muscle and/or Bone Issues	YES	NO
Back Pain		
Traumatic injury *(what?)*		
Sports Injury *(what?)*		
Broken Bones *(which one(s)?)*		
Social History	YES	NO
Smoking If yes, how much?		
If quit, when?		
Alcohol If yes, how much?		

Lung or Breathing Issues	YES	NO
Shortness of breath		
Asthma		
Chronic obstruct. pulmonary disease		
Tuberculosis		
Endocrine Issues	YES	NO
Diabetes *(If yes, how controlled?*		
Circle: diet, medication, exercise)		
Kidney/Urinary Issues	YES	NO
Dialysis		
Dialysis access *(permacath, fistula, graft,*		
peritoneal dialysis catheter?		
High blood pressure due to renal artery		
problems		

Other Issues not previously listed:

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

Surgery	**Date**	**Where**

Revised: 6/2009