Greater Lowell Vascular Surgery

Complete connected care℠

NAME: _____ / DOB: _____ PATIENT HISTORY

Do you have a Health Care Proxy? _____

What is the reason for your visit? _____

If applicable, have you had any recent tests (lab, x-rays, etc.) to evaluate the problem? ☐ Yes ☐ No

If yes, which tests/facility? _____

GENERAL HEALTH HISTORY

Do you have?		Yes	No	Do you have?		Yes	No
Const	Fever, chills, general weakness			*Gastro*	Nausea/vomiting		
Const	Recent weight change			*Gastro*	Abdominal pain or cramps		
H&N	Ear pain			*Gastro*	Constipation or diarrhea		
H&N	Hoarseness			*Urine*	Blood in urine		
Skin	Changing mole			*Urine*	Pain or burning while urinating		
Skin	Recent rash			*GYN*	Vaginal discharge		
Glands	Swollen glands			*GYN*	Abnormal bleeding		
Glands	Painful glands			*GYN*	Are you pregnant?		
Heart	Chest pain			*GYN*	Breast lump or mass		
Heart	Fluttering of heart			*Men*	Lump or mass in testicle		
Lung	Shortness of breath			*Men*	Discharge from penis		
Lung	New, frequent cough			*Neuro*	Dizzy spells, fainting		
				Musc	Bone or joint pain		

Comments on any of the above: _____

PERSONAL MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Heart Attack			Diabetes			Cancer		
High Blood Pressure			Emphysema			Liver Disease		
Stroke			Bleeding Disorder			Blood Clots		
Asthma			Kidney Disease			Seizures		

Other (please explain): _____

On a scale from 1 to 10, **10 being the most severe pain**, what is your current level of pain? _____

Yes *No*

☐ ☐ Have you, or anyone related to you, ever had a problem with anesthesia?

☐ ☐ Have you had any surgery before? If yes, please list type and approximate year:

_____

☐ ☐ If there any significant history of illness in your family? If yes, please explain:

_____

☐ ☐ Have you recently been exposed to any infectious diseases (e.g. chicken pox, TB, HIV)?

☐ ☐ Do you smoke? If yes, how many packs per day? _____ Number of years? _____

Previous Smoker: When/how many years has it been since you quit? _____

☐ ☐ Do you drink more that 1-2 alcoholic drinks per day? If yes, how many? _____

☐ ☐ Are you now or have you ever been a victim of physical, emotional or financial abuse?

Date: ____ / ____ / ____