PATIENT HISTORY FORM

Vascular Institute of the Midwest

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NAME: _____ Today's Date: _____/_____/_____

Last First M. I. Birthdate: _____/_____/_____

Briefly describe your present symptoms: Age: _____ Sex: ❑ F ❑ M

ALLERGIES / CURRENT MEDICATIONS

Drug allergies:
❑ No ❑ Yes, To what?

Latex allergy:
❑ No ❑ Yes

Contrast allergy:
❑ No ❑ Yes

Please list any medications that you are now taking. (Include non-prescription medications & vitamins or supplements)

Name of drug	Dose (include strength & number of times / day)

PERSONAL / SOCIAL HISTORY

Have you ever used tobacco products? ❑Yes ❑No
❑Cigarettes ❑Cigars ❑Pipe ❑Chew
Age started_____ Amount/day_____

(if yes) Do you currently use tobacco products? ❑Yes ❑No
Age quit _____

Do you regularly drink alcohol?
❑Rarely ❑Socially ❑Daily

Do you use illicit drugs? (including marijuana) ❑No ❑Yes
What? _____

Marital status: ❑ Never married ❑ Married
❑ Divorced/Separated ❑ Widowed

What is your current or past occupation?

Are you currently working? ❑ Yes ❑ No
If not, are you ❑ retired ❑ disabled

FAMILY HISTORY ❑ Family History Unknown

	IF LIVING		IF DECEASED	
	Age	Medical History	Age at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY MEDICAL PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician initials _____