Welcome to Vascular Institute!

We are OBSESSED with Patient Care! It all starts with getting to know you, to ensure we provide the best possible care. There is a lot here, but we know you can do it! Please fill out the information below as completely as possible. As always, if you have any questions, all of us will help (but maybe not all of us at once).

Patient Name: _____ **Date of Birth:** _____

Past Medical History

Please indicate if you have had any of the following by marking the corresponding check box.

Cardiovascular

- ☐ Heart Disease
- ☐ Stroke
- ☐ Myocardial Infarction (Heart Attack)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Chest Discomfort
- ☐ Angina
- ☐ Palpitations
- ☐ Arrhythmia (skipped heart beats)
- ☐ Fluttering feeling in chest
- ☐ Atrial Fibrillation (rapid heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (heart disease)
- ☐ Swelling in ankles or feet

Ear, Nose and Throat

- ☐ Ear, nose, throat problems
- ☐ Eye Disease
- ☐ Hearing Impaired
- ☐ Allergies

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Autoimmune Disorder
- ☐ Kidney Disease

Musculoskeletal

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness

Infectious Disease

- ☐ HIV
- ☐ Hepatitis
- ☐ C-diff

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea

Neurological

- ☐ Neurological Disease
- ☐ Epilepsy
- ☐ Chronic Headaches
- ☐ Numbness and Tingling
- ☐ Alzheimer's / Dementia
- ☐ Multiple Sclerosis
- ☐ Memory Loss

Psychiatric

- ☐ Anxiety
- ☐ Depression

Other

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Thoracic/Abdominal Aneurysm

Vascular

- ☐ DVT
- ☐ Venous Insufficiency
- ☐ Peripheral Artery Disease

Cancer

- ☐ Cancer (specify type below)

  _____

- ☐ Cancer Treatment (specify below)

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