CALIFORNIA VASCULAR & VEIN CENTER

HEALTH APPRAISAL QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

BIRTHDATE: _____ **AGE:** _____ **SEX:** _____ **WEIGHT:** _____ **HEIGHT:** _____

MARITAL STATUS: MARRIED / DIVORCE / WIDOWED / SINGLE

REFFERED BY: _____

PRIMARY MD: _____

REASON FOR REFERRAL: _____

HAVE YOU OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING:

	YES	NO
Swelling of ankles, feet or stomach……..	☐	☐
Dizziness, lightheadedness, blackouts, or fainting?.....	☐	☐
Temporary loss/disturbance of speech?.....	☐	☐

	YES	NO
Pain, discomfort or cramping in legs	☐	☐
When walking?……	☐	☐
Temporary weakness of one side of	☐	☐

Other: _____

CURRENT/ PAST MEDICAL HISTORY	YES	NO	
Coronary Heart Disease……	☐	☐	Month/ Year _____
Heart Attack……	☐	☐	Month/ Year _____
Cardiac Catheterization/Angiogram……	☐	☐	Month/ Year _____
Bypass Surgery……..	☐	☐	Month/ Year _____
Stroke……..	☐	☐	Month/ Year _____
Mini Stroke/TIA……	☐	☐	Month/ Year _____
Peripheral Vascular Disease……	☐	☐	Month/ Year _____
Blood Clots (Lungs☐ Extremities☐)……	☐	☐	Month/ Year _____
Aneurysm……	☐	☐	Month/ Year _____
Hypertension……	☐	☐	Month/ Year _____
High Cholesterol……	☐	☐	Month/ Year _____
Diabetes……..	☐	☐	Month/ Year _____
Cancer (Specify_____)	☐	☐	Month/ Year _____
Other (Specify_____)	☐	☐	Month/ Year _____

DO YOU HAVE ANY ALLERGIES: ☐ **YES** ☐ **NO**
SPECIFY (IODINE, SEAFOOD or MEDICATIONS?) _____

SOCIAL HISTORY

TOBACCO USE: CURRENT USE ☐ **YES** ☐ **NO – IF YES, AMOUNT** _____ **/ DAY HOW LONG?** _____
IF HISTORY OF SOMKING, WHEN DID YOU QUIT _____ **AMOUNT** _____

ALCOHOL USE: CURRENT USE ☐ **YES** ☐ **N HOW LONG?** _____ **STREET DRUGS:** ☐ **YES** ☐ **NO**

FAMILY HISTORY

			FAMILY MEMBER
HEART DISEASE	☐ **YES**	☐ **NO**	_____
HIGH CHOLESTEROL	☐ **YES**	☐ **NO**	_____
H BLOOD PRESSURE	☐ **YES**	☐ **NO**	_____
STROKE	☐ **YES**	☐ **NO**	_____
CANCER	☐ **YES**	☐ **NO**	_____
DIABETES	☐ **YES**	☐ **NO**	_____
PAD	☐ **YES**	☐ **NO**	_____

REVIEW OF SYMPTOMS

DO YOU CURRENTLY, OR HAVE EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS?

GENERAL	**YES**	**NO**
Tire easily, Weakness…..	☐	☐
HEAD/NECK		
Headache……..	☐	☐
Migraine……	☐	☐
Lumps in Neck……..…	☐	☐
Blocked Arteries in Neck	☐	☐
Double vision…….	☐	☐
Speech problems	☐	☐
Numbness/weakness in		
Arms & legs…….……	☐	☐
EYES/EARS/NOSE/ THROAT		
Blurred Vision…….	☐	☐
GASTROINTESTINAL		
Diverticulitis……..…	☐	☐
Ulcers……	☐	☐
Intestinal Bleeding…	☐	☐
Liver Disease…….	☐	☐
Hepatitis	☐	☐
Diarrhea……	☐	☐
Poor Appetite……	☐	☐
**Constipation…….. **	☐	☐
**Indigestion……. **	☐	☐
**Heartburn……... **	☐	☐
ENDOCRINE		
**Thyroid problems……... **	☐	☐
Diabetes…….	☐	☐
GENITOURINARY		
Bladder Problems……	☐	☐
**Frequent urination……. **	☐	☐
Kidney disease…….	☐	☐
Erectile dysfunction……	☐	☐
Other (specify) _____		
SKIN		
Rashes……	☐	☐
Hives……	☐	☐
Skin Cancer……..	☐	☐
Depression……	☐	☐

PULMONARY	**YES**	**NO**
Chromic Bronchitis……	☐	☐
Emphysema……	☐	☐
BONES/JOINTS/MUSCLE		
Muscle pain/ weakness……	☐	☐
Joint pain/ swelling……..…	☐	☐
Arthritis……..…	☐	☐
Back Problems……..…	☐	☐
Gout……	☐	☐
HEMATOLOGY		
Anemia……..……..…	☐	☐
Bleeding Problem……..…	☐	☐

FEMALES ONLY:

HAVE YOU HAD A TOTAL HYSTERECTOMY ?
(OVARIES AND UTERUS REMOVED)
YES ☐ NO☐

ARE YOU TAKING BIRTH CONTROL PILLS OR HARMONE REPLACEMENT?
YES ☐ NO ☐

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU TAKE REGULARLY

MEDICATION	**DOSE (MG)**	**TIMES A DAY**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____