Surgical Associates of San Diego

www.sdvascularcenter.com

THE INFORMATION YOU PROVIDE ALLOWS US TO GIVE YOU THE BEST TREATMENT OPTIONS

PRESENT VISIT: PLEASE DESCRIBE TO THE BEST OF YOUR ABILITY, YOUR ILLNESS.

PLEASE LIST YOUR MEDICAL PROBLEMS:

PLEASE LIST YOUR PREVIOUS SURGERIES:

DATE:	OPERATION	DOCTOR

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

WHAT MEDICATIONS DO YOU TAKE?

NAME	DOSAGE	PERSCRIBING DOCTOR

HAVE YOU RECEIVED BLOOD TRANSFUSIONS? YES __________ NO ___________

HAVE YOU EVER SMOKED? YES_______ NO _________ How Many Years? ____________

HAVE YOU EVER USED ALCOHOL? YES______ NO_____ **How Many Years?____________**

YOUR FAMILY MEDICAL HISTORY:

Parents: Deceased: Yes___ No___ Age ______ Medical Conditions: _________________________________

Siblings: Deceased: Yes___ No___ Age ______ Medical Conditions:________________________________

Children: Deceased: Yes ___ No___ How Many_____ Ages ___ ___ ___ ___ ___ ___

Please Check All That Apply

Cancer		Heart Problems		High Blood Pressure		Amputations	
Melanoma		Diabetes		Kidney Disease		Aneurysms	
Stomach Problems		Bleeding Problems		Stoke		Gangrerne	

PLEASE REVIEW AND CHECK IF <u>YOU</u> HAVE:

	Kidney Failure			Cirrhosis
	Diabetes			Bleeding Gums
	Thyroid Trouble			Hepatitis
	HIV Positive			Hemophilia

<u>HEART:</u> Check each box that applies.

	Pacemaker			**Heart Attack**
	Heart Bypass			**Angioplasty**
	High Blood Pressure			**Heart Failure**
	Difficulty Walking			**Irregular Heart Beat**
	Chest Pain			**High Cholesterol**

<u>RESPIRATORY:</u> Check each box that applies.

	Short of Breath			
	Blood in Sputum			
	Cough			
	Hoarseness			
	Emphysema			

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GASTROINTESTNAL: Check each box that applies.

	Hepatitis			**Gallstones**
	Weight Loss	**______lbs Loss**		**Intestinal Trouble**
	Hemorrhoids			**Hiatal Hernia**
	Blood in Stool			**Vomiting Blood**
	Ulcer Disease			**Diverticulitis**
	Crohn's Disease			**Ulcerative Colitis**
	Colon Cancer			

NEUROLOGIC: Check each box that applies.

	Paralysis / Weakness			
	Loss of Vision			
	Fainting / Spinning			
	Stroke / Weakness			
	Numbness			
	Seizures			
	Diziness			

PSYCHIATRIC: Check each box that applies.

	Mental Illness			
	Psychiatrist Visits			

GENITOURINARY: Check each box that applies.

	Frequent Urination			**Prostate Enlargement**
	Painful Urination			**Impotence**

MUSCULOSKELETAL: Check each box that applies.

	Arthritis			**Osteoporosis**
	Spine Problems			**Difficulty Walking**

I understand that the above information is required to provide me with the proper medical care in a safe and efficient fashion. I have completed the questions to the best of my knowledge. Should further information be needed, I give my consent to ask the respective health care provider or agency to release any necessary information. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Name: ____
Signature ____

Date ____________________