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| **Vascular Associates of Michigan, P.C.**  **Health History Questionnaire** | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  And will become part of your medical record. | | | | | | | |
| **Name (Last , First, M.I)** | | | | **D.O.B** | | | |
|  | | | | | | | |
| **List any medical problems that other doctors have diagnosed. Please check mark all that apply.** | | | | | | | |
| High Cholesterol | | Stroke | | | | Emphysema/ Asthma/ COPD | |
| High Blood Pressure | | Kidney Disease | | | | Carotid Artery Disease | |
| Diabetes | | Peripheral Vascular Disease | | | | Aneurysm | |
| Coronary Artery Disease | | Heart Attack | | | | Congestive Heart Failure | |
| Other | |  | | | |  | |
|  | |  | | | |  | |
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|  | |  | | | |  | |
| List any prior surgeries | | | | | | | |
| Month / Year | | | Surgery / Reason | | | | Hospital |
|  | | |  | | | |  |
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|  | | |  | | | |  |
| Pain Describe Severity of Pain (least=1, Worst=10) | | | | | | | |
| Legs: With walking | Distance | | | | **1 2 3 4 5 6 7 8 9 10** (circle) | | |
| Legs: At rest |  | | | | **1 2 3 4 5 6 7 8 9 10** (circle) | | |
| Chest Pain |  | | | | **1 2 3 4 5 6 7 8 9 10** (circle) | | |
| Arm Pain: |  | | | | **1 2 3 4 5 6 7 8 9 10** (circle) | | |
| Other Pain- describe |  | | | | **1 2 3 4 5 6 7 8 9 10** (circle) | | |

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| **HEALTH HABITS AND PERSONAL SAFETY** | | | | | |
| **EXERCISE** | Sedentary (No exercise) | | | | |
| Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| Occasional vigorous exercise (i.e., work or recreation, less than 4x/ week for 30 mins.) | | | | |
| Regular vigorous exercise (i.e., work or recreation, less than 4x/ week for 30 mins.) | | | | |
| Type of exercise: walk exercise bike treadmill swim jog other | | | | |
| Do you plan to exercise? Yes No | | | | |
| Are you currently or have participated in a Cardiac Rehab exercise program? Yes No | | | | |
| Tobacco | Do you use (or have you ever used) tobacco regularly? Yes No | | | | |
| Cigarettes\_\_\_\_\_\_ pks./day | | | | Chew Pipe Cigars amount/ day\_\_\_\_\_ |
| Number of Years \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Quit year\_\_\_\_ Started smoking again year\_\_\_\_ |
| Have you tried to quit? | | | | |
| Methods used or tried: Nicotine patch / gum/ inhaler Zyban (Wellbutrin) Chantix Other | | | | |
| Do you currently want to quit? Yes No | | | | |
| Does your spouse smoke? Yes No | | | | |
| Are you exposed to second hand smoke at home or work? Yes No | | | | |
|  | | | | |
| Personal  Safety | Do you have any problems with memory? Yes No | | | | |
| Do you have frequent falls? Yes No | | | | |
| Do you have vision or hearing loss? Yes No | | | | |
| **FAMILY HEALTH HISTORY** | | | | | |
|  | | Age | | SIGNIFICANT HEALTH PROBLEMS | |
| Father | |  | |  | |
| Mother | |  | |  | |
| Children | | M  F |  |  | |
| M  F |  |  | |
| M  F |  |  | |
| M  F |  |  | |
| M  F |  |  | |
| M  F |  |  | |
|  |  |  | |

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health.

Rev 12/13