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| **Vascular Associates of Michigan, P.C.****Health History Questionnaire** |
| All questions contained in this questionnaire are strictly confidentialAnd 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 |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| List any prior surgeries |
|  Month / Year |  Surgery / Reason |  Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| 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 |
|  |
| PersonalSafety | 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