Grapevine Surgery and Vein Clinic
Patient History and System Review

Patient Information ***Today's Date:***

Name: _____ ***Age:*** _____ ***DOB:*** _____

Referring M.D.: _____ ***Primary Care Physician:*** _____

Other Treating Physicians & specialty (if applicable): _____

_____

Reason for Visit: _____

Medical and Surgical History

Medical *(High blood pressure, Diabetes, Heart Disease, etc.)*

*1.*_____ *#Years*_____ *4.*_____ *#Years*_____
*2.*_____ *#Years*_____ *5.*_____ *#Years*_____
3. _____ *#Years*_____ *6.*_____ *#Years*_____

Surgeries *(Appendectomy, Gallbladder, Hernia, Hysterectomy, etc)*

*1.*_____ *#Years*_____ *4.*_____ *#Years*_____
*2.*_____ *#Years*_____ *5.*_____ *#Years*_____
*3.*_____ *#Years*_____ *6.*_____ *#Years*_____

Date of Last: *Physical:* _____ *Did you have (please circle)* ***Blood EKG Chest X-ray***

Colonoscopy: _____ *Mammogram:* _____ *Pap Smear:* _____

Family History

	Living	*Deceased*	*Illness*	*Cause of Death/@ Age*
Father				
Mother				
Brother (s)				
Sister (s)				

Is there a history of the following in your family?

	Yes	*No*	*Family Member*
1. Heart Disease	_____	_____	_____
2. Cancer & Type	_____	_____	_____
3. Diabetes	_____	_____	_____

Social History

Smoke: *Yes or No If yes, #packs /day:* _____ *# Years*_____

When did you stop? _____ *Other tobacco use:* _____

Alcohol: *Yes or No If yes, how much?* _____ *How often?* _____

Occupation: _____ ***Marital Status:*** _____

Name: _____ ***DOB:*** _____

Medications

*1.*_____*#*_____*Day*
*2.*_____*#*_____*Day*
*3.*_____*#*_____*Day*
*4.*_____*#*_____*Day*
*5.*_____*#*_____*Day*
*6.*_____*#*_____*Day*

Non-prescription Medication (Advil, aspirin, Tylenol, Vitamins, etc

_____ _____

_____ _____

Allergies

***None*_____ *Latex* _____ *Tape* _____**

Medicine/Reaction:

_____ _____

_____ _____

Review of Systems

Do you now or have recently had any of the following? Please circle yes or no.

General			***Eyes***			***ENT***			***Gastrointestinal***		
Weight gain/loss	*Y*	*N*	*Pain*	*Y*	*N*	*Sore Throat*	*Y*	*N*	*Abdominal Pain*	*Y*	*N*
Fever/chills	*Y*	*N*	*Discharge*	*Y*	*N*	*Hoarseness*	*Y*	*N*	*Nausea/vomiting*	*Y*	*N*
Fatigue	*Y*	*N*	*Light Sensitivity*	*Y*	*N*	*Ringing in ears*	*Y*	*N*	*Diarrhea/Constipation*	*Y*	*N*
Loss of appetite	*Y*	*N*	*Blurred Vision*	*Y*	*N*	*Nose Bleeds*	*Y*	*N*	*Heartburn*	*Y*	*N*
Night Sweats	*Y*	*N*	*Double Vision*	*Y*	*N*	*Hearing Loss*	*Y*	*N*	*Blood in stool*	*Y*	*N*
Other:			*Other:*			*Other:*			*Other:*		
Cardiovascular			***Genitourinary***			***Musculoskeletal***			***Skin/Breast***		
Chest pain	*Y*	*N*	*Frequency*	*Y*	*N*	*Muscle/Joint pain*	*Y*	*N*	*Rash*	*Y*	*N*
Palpitations	*Y*	*N*	*Incontinence*	*Y*	*N*	*Joint swelling*	*Y*	*N*	*Moles*	*Y*	*N*
Calf/Leg Pain	*Y*	*N*	*Flank pain*	*Y*	*N*	*Weakness*	*Y*	*N*	*Sores*	*Y*	*N*
Shortness of breath	*Y*	*N*	*Blood in urine*	*Y*	*N*	*Poor balance*	*Y*	*N*	*Breast Discharge*	*Y*	*N*
Other:			*Other:*			*Other:*			*Other:*		
Respiratory			***Hematological***			***Endocrine***			***Psychological***		
Wheeze	*Y*	*N*	*Easy Bruising*	*Y*	*N*	*Excessive sweating*	*Y*	*N*	*Anxiety*	*Y*	*N*
Cough	*Y*	*N*	*Swollen glands*	*Y*	*N*	*Excessive thirst*	*Y*	*N*	*Depression*	*Y*	*N*
Bloody sputum	*Y*	*N*	*Excessive bleeding*	*Y*	*N*	*Excessive heat/cold*	*Y*	*N*	*Stress*	*Y*	*N*
Other:			*Other:*			*Other:*			*Other:*		
Neurological			***Explanations:***								
Headaches	*Y*	*N*									
Confusion	*Y*	*N*									
Dizziness	*Y*	*N*									
Memory Loss	*Y*	*N*									
Seizure	*Y*	*N*									
Other:											

Patient Signature: _____ ***Date:*** _____

Health History and ROS reviewed by: _____***Date:***_____