NASHVILLE VASCULAR & VEIN INSTITUTE

MEDICAL QUESTIONAIRE

Please fill out both sides of this form, If you have a list of your medications and/or surgeries please attach.

Today's Date:_____ **Date of appointment:** _____

Name: _____ ☐ M ☐ F **DOB:** _____ **Age**: _____

Pharmacy Name and Location:	**Pharmacy Phone:**
What problem are you seeing the doctor for today?	
Have you been treated for this in the past?	**If Yes, when?**

List your prescribed drugs and over-the-counter drugs, such as Aspirin and inhalers, if none, write NONE

Name the Drug		

Allergies - ☐ **I have no allergies to medicines, or list allergies to medications**

Name the Drug	**Reaction You Had**

Other medical conditions that you are being treated for (please check all that apply)			
	☐ Cancer	☐ Kidney disease	☐ Vascular disease
	☐ Diabetes	☐ Stroke	☐ High cholesterol
	☐ Heart disease (CAD)	☐ Hypertension	☐ Respiratory problems (COPD)
	☐ Liver disease (hepatitis)	☐ Varicose Veins	☐ No Significant Medical History

☐ HIV ☐ Congestive Heart Failure ☐ Other _____

Surgeries

Year	Reason	Hospital

330 23rd Ave. N. Suite 100
Nashville, TN 37203
P (615)321-6100 / F (615)321-6200

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Do you have a family history of?				
Stroke	**Diabetes**	**Heart Disease**	**High Blood Pressure**	**Cancer (if so what type)**
Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother
Sister	Sister	Sister	Sister	Sister
Brother	Brother	Brother	Brother	Brother
Grandfather	Grandfather	Grandfather	Grandfather	Grandfather
Grandmother	Grandmother	Grandmother	Grandmother	Grandmother
Aunt	Aunt	Aunt	Aunt	Aunt
Uncle	Uncle	Uncle	Uncle	Uncle

Tobacco	Do you use tobacco? ☐ Yes ☐ No ☐ Former Smoker # of Years _____ or Quit Date _____			
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Alcohol Use	☐ Yes	☐ No If yes, how much, how often? Beer _____ Wine_____ Hard Liquor _____		

This questionnaire is for the past year only. Please Circle if it applies. Thank you!

Constitutional: chills, fever, weight gain/loss, decline in health, weakness, fatigue,	**Gastrointestinal**: abdominal pain, jaundice, hepatitis, constipation, liver disease, diarrhea, gallbladder disease	**Hematologic**: bleeding easily, blood clots, easy bruisability
Head: dizziness, fainting, headaches	**Musculoskeletal**: arthritis, muscle stiffness, back problems, paralysis, muscle cramps, weakness	**Allergy/Immunology**: coughing, recurrent infections, wheezing with exercise
Eyes: Blurry vision, injury, vision loss	**Psychiatric**: depression, hallucinations, behavioral change, nervousness, excessive stress, psychiatric disorders	**Neurologic**: loss of consciousness, memory loss, speech disorder, blackouts, numbness, strokes, headaches, paralysis, unsteady gate
Mouth: bleeding gums, change in dentition, hoarseness	**Cardiovascular**: chest pain, extremity discolored, high blood pressure, shortness of breath, swelling of the legs, varicose veins, hair loss on legs, history of heart attack, ulcers on legs, extremity cool, abnormal heart tests, leg pain walking/rest.	**Endocrine**: weakness, weight gain, weight loss
Ears: dizziness, hearing impairment, infections	**Skin**: dryness, skin color change, easy bruisability, nail appearance change	**Respiratory**: cough, pain, wheezing, positive TB test, Bronchitis, tuberculosis
Throat & Neck: lumps, tenderness, tonsils enlarged	**Urinary**: burning, difficulty starting stream, excessive urination	

To the best of my knowledge, the above information is accurate and complete

_____ Patient (or authorized signature)

_____ Date

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