



VASCULAR INSTITUTE

OF CENTRAL FLORIDA

2501 N. Orange Ave., Suite 200 Orlando, Florida 32804 T/407-303-7250 F/407-303-7255

INITIAL / CONTINUING HEALTH HISTORY

PATIENT NAME: _____ D.O.B.: _____

REVIEW OF SYSTEMS	
GENERAL	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headache <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain
MUSCULO-SKELETAL	<input type="checkbox"/> Joint Pain - where? _____ <input type="checkbox"/> Pain / Weakness / Numbness - where? _____
EYES	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Vision Loss <input type="checkbox"/> Glasses
EARS / NOSE / THROAT	<input type="checkbox"/> Sinusitis <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Cough
PULMONARY	<input type="checkbox"/> Short of Breath: <input type="checkbox"/> Always <input type="checkbox"/> at Night <input type="checkbox"/> Oxygen at Home
CARDIO-VASCULAR	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Swelling <input type="checkbox"/> Leg Pain with Walking - at Rest
GASTRO-INTESTINAL	<input type="checkbox"/> Poor Appetite <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Belly Pain
GENI-TOURINARY	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Loss of Bladder Control
INTEGUMENT	<input type="checkbox"/> Skin Lesions
NEUROLOGIC	<input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Arm / Leg Function
ENDOCRINE	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Lupus
HEMATOLOGIC	<input type="checkbox"/> Bleed / Bruise <input type="checkbox"/> Anemia
PSYCHIATRIC	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Sleep Problems
IMMUNOLOGIC	<input type="checkbox"/> Lymphadenopathy

(All Information is Strictly Confidential)

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease Relationship to You	
Father					Aneurysm	
Mother					Arthritis, Gout	
Brothers					Asthma, Hay Fever	
					Cancer	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Other	

SURGERIES

Year	Hospital	Surgery

PREGNANCY HISTORY

of Abortions: _____
of Living Children: _____
of C-Sections: _____

MEDICAL CONDITIONS

SOCIAL HISTORY

TOBACCO:
Type _____ Amount _____
Age at Start _____ Age Quit _____

ALCOHOL:
Beer / Wine / Liquor _____ Amount _____
Age at Start _____ Age Quit _____

CAFFEINE: _____

OCCUPATION: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____