HORIZON VASCULAR SPECIALISTS
HEALTH INVENTORY AND HISTORY

PATIENT NAME:_____ **DATE:**_____

SYMPTOMS/REASON for today's visit:_____

Please list all ALLERGIES to foods, medications, and/or environmental: _____

MEDICATION (include any over the counter vitamins and supplements):

NAME/DOSE/HOW OFTEN:	NAME/DOSE/HOW OFTEN:

PLEASE CIRCLE ALL THAT APPLY:

Constitutional:	Fever Night Sweats Weight Gain Weight Loss Exercise
Eyes:	Eye pain Cataracts Vision Changes Blindness Temporary Vision Loss
Ears, Nose, Throat:	Difficulty Hearing Ringing in Ears Nose Bleeds Sinus Problems Difficulty Swallowing
Cardiovascular:	Heart Disease A-Fib Pacemaker/Defibrillator Chest Pain Arm Pain Palpitations Murmur **Cardiologist**: _____
Vascular:	High Blood Pressure High Cholesterol Diabetes Deep Vein Thrombosis (DVT) Kidney Disease Kidney Failure Aneurysm Carotid Disease Peripheral Arterial Disease
Respiratory:	Shortness of Breath Cough Sleep Apnea COPD/Asthma/ Emphysema
Gastrointestinal:	Abdominal Pain Vomiting/Nausea Diarrhea/Constipation Change in Appetite Blood in Stool Black Stool Reflux
Genitourinary:	Blood in Urine Incontinent/Loss of Bladder Control Urinary Frequency
Hematology:	Abnormal Bleeding Easily Bruised Abnormal Clotting
Musculoskeletal:	Muscle Ache Leg Pain with Walking Neck Pain Back Pain Joint Pain Swelling: Legs/Feet/Arms/Hands

Neurologic:	Difficult to Speak Difficult to Find Words Stroke TIA/Mini-Stroke Numbness Hands/Feet
Skin:	Open Sores Rash Weeping Growths/Lesions Itching Skin Discoloration
Endocrine:	Dialysis Thyroid Disease Hepatitis Cancer Autoimmune Disorder
Psychological:	Depression Anxiety

Social History

Smoking:	Never Smoker Current Smoker Former Smoker/Date Quit _____
Alcohol Use:	Non-Drinker Drinks in the last year/amount and frequency _____
Drug Use:	Never Often Occasional Substance _____

Please specify any health issues not previously mentioned:

_____

_____

Major health problems of PARENTS:

Mother □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Cancer
Father □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Cancer

Do you have an Advance Directive? Yes No
Have you had an Influenza vaccine since the last September 1st" Yes No
Have you had a Pneumonia vaccine? Yes No

SURGERY: (please include any catheterizations or stents)

NAME/DATE/DOCTOR:	NAME/DATE:

Height: _____ Weight: _____