English - Spanish

Northside VASCULAR SURGERY

Catalin Harbuzariu, MD • **Edward Kang**, MD • **Siddharth A. Patel**, MD

NORTHSIDE HOSPITAL HEART & VASCULAR INSTITUTE

PATIENT MEDICAL HISTORY

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Self Medical History:

Please indicate whether YOU have had any of the medical illnesses listed below (check all that apply).

Sensory Defects
- Loss of Hearing or Deaf ☐ Yes
- Loss of Vision or Blind ☐ Yes

Respiratory (Lung or Breathing Problems)
- Asthma / Wheezing ☐ Yes
- Emphysema / COPD ☐ Yes
- Sleep Apnea ☐ Yes

Cardiac (Heart Problems)
- Fast Heart Rate Requiring Therapy ☐ Yes
- Heart Attack / Angioplasty / CABG ☐ Yes
- Heart Failure ☐ Yes
- Heart Murmur ☐ Yes
- High Blood Pressure ☐ Yes
- High Cholesterol ☐ Yes

Vascular (Circulation Problems)
- Aneurysm ☐ Yes
- Peripheral Artery Disease ☐ Yes
- Varicose veins ☐ Yes
- Wounds or Sores ☐ Yes

Gastrointestinal (GI or Abdominal Problems)
- Gallbladder Problems ☐ Yes
- Hepatitis ☐ Yes
- Liver Disease ☐ Yes
- Ulcers ☐ Yes

Renal (Kidney Problems)
- Kidney Failure ☐ Yes
- Kidney Disease ☐ Yes
- Kidney Stones ☐ Yes

Immunologic / Infectious Disease
- AIDS ☐ Yes
- HIV ☐ Yes
- Auto-Immune (e.g. Lupus) ☐ Yes

Endocrine
- Diabetes ☐ Yes
- Low Blood Sugar ☐ Yes
- Thyroid Problems ☐ Yes

Musculoskeletal (Bone, Joint, or Muscle Problems)
- Arthritis ☐ Yes
- Osteoporosis ☐ Yes

Neurological (Brain or Nerve Problems)
- Headaches / Migraines ☐ Yes
- Parkinson's / Tremor ☐ Yes
- Seizures ☐ Yes
- Stroke ☐ Yes
- TIA ☐ Yes

Mental Health
- Alzheimer's / Dementia ☐ Yes
- Anxiety ☐ Yes
- Depression ☐ Yes
- Mental Illness ☐ Yes

Hematologic (Blood Problems)
- Anemia ☐ Yes
- Bleeding Disorder ☐ Yes
- Clotting Problems ☐ Yes

Oncologic (Cancer)
- If yes, what type? _____
- Chemotherapy ☐ Yes
- Radiation Therapy ☐ Yes

Other Medical Illnesses (please list)

_____

_____

_____

_____

_____

_____

Atlanta
980 Johnson Ferry Road
Suite 1040
Atlanta, GA 30342

Cherokee
460 Northside Cherokee Blvd.
Suite 100
Canton, GA 30115

Forsyth
1505 Northside Blvd.
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Cumming, GA 30041

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Today's Date: _____

Patient Name: _____

Date of Birth: _____

Family Medical History:

Please indicate whether any of your **BLOOD RELATIVES** have any of the medical illnesses listed below. (List relationship)

- ☐ Aneurysm _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Artery Blockage in Legs _____
- ☐ Kidney Problems _____
- ☐ DVT _____
- ☐ Varicose Veins _____
- ☐ Bleeding Disorders _____

Previous surgeries or hospitalizations:

Reason	Date	Hospital Name	Any Complications

Social History

Do you currently smoke? ..... ☐ Yes ☐ No

How long have you been smoking? _____ months _____ yrs

How many cigarettes per day? _____

If you don't currently smoke, have you ever smoked? ..... ☐ Yes ☐ No

Do you use Smokeless Tobacco/Vapors? ..... ☐ Yes ☐ No

How often? _____

Do you drink Alcohol? ..... ☐ Yes ☐ No

How often? _____

Any history of drug use? ..... ☐ Yes ☐ No

Do you Work? ..... ☐ Yes ☐ No

What is your occupation? _____

Retired? _____

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