



Vascular Health Center

Comprehensive Vascular Care

Tarek El-Shaarawy, M.D.

Syed M. Faisal Alam, M.D.

PATIENT PERSONAL HEALTH HISTORY FORM

PATIENT NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ MALE / FEMALE / OTHER (Circle One) Explain Other _____

HEIGHT _____ WEIGHT _____

PRIMARY CARE PROVIDER _____

PRIMARY CARE PROVIDER'S ADDRESS/PHONE _____

PHARMACY NAME _____

PHARMACY ADDRESS/PHONE _____

ALLERGIES

LIST ALL ALLERGIES: _____

REASON FOR VISIT

LIST REASON FOR VISIT: _____

CURRENT HEALTH SYMPTOMS

Please check all that apply to you:

☐	Pain in legs or feet	☐	Swelling	☐	Stroke/TIA
☐	Numbness/Tingling	☐	Wounds or ulcers on legs	☐	Vision Loss/changes:
☐	Weakness in arms/legs	☐	Varicose or spider veins	☐	Low back/abdominal pain
☐	Leg Cramps	☐	Leg pain with exertion	☐	Other

MEDICAL HISTORY

Please check all that apply:

	Lung Disease		High Blood Pressure		Bleeding/Clotting Disorders
	Heart Disease		High Cholesterol		Kidney Disease
	Stroke		Diabetes		Other

FAMILY HISTORY

Please check all that apply:

Stroke		Father		Mother		Sibling
Diabetes		Father		Mother		Sibling
Heart Disease		Father		Mother		Sibling
Aneurysm		Father		Mother		Sibling
Clotting Disorder		Father		Mother		Sibling

SURGICAL HISTORY

Please list all your past surgeries:

Surgery	Date/Year

MEDICATIONS

Please list all medications, including over the counter medications:

Medication	Dose	Frequency

SOCIAL AND PERSONAL HABITS

Tobacco Use	Y	N	Previous?	Amount Per Day	Number of Years
Do you smoke cigarettes?					
Do you smoke cigars/pipe?					
Do you vape?					
Alcohol Use	Y	N	Previous?	Amount Per Day	Number of Years
Do you drink alcohol?					
Recreational Drug Use	Y	N	Previous?	Type	Number of Years
Do you use recreational drugs?					
Exercise	Y	N	Type	Frequency	
Do you exercise?					

By signing this form, you are authorizing that to the best of your knowledge the above information is accurate.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

DATE SIGNED