East Hawaii Health
73 Pu`uhonu
Vascular Surgery

Patient Name: _____ Birthdate: _____

SUPPLEMENTAL MEDICAL QUESTIONAIRE

What is your reason for seeing the surgeon? _____

Have you travelled outside the state in the past 30 days? [ ] Yes [ ] No

Have you had a pneumococcal vaccine? [ ] Yes [ ] No

Are you in pain? [ ] Yes [ ] No If yes, where? _____

Thoughts of suicide? [ ] Yes [ ] No

Are you frightened at home? [ ] Yes [ ] No

Quality of pain: [ ] Cramping [ ] Squeezing [ ] Burning [ ] Stinging [ ] Stabbing [ ] Other: _____

On a scale of 1 (weak) to 10 (extreme), how severe is your pain? _____ How long does it usually last? _____

Have you fallen in the past 12 months? [ ] Yes [ ] No Are you a smoker? [ ] Yes [ ] No [ ] Former

ALLERGIES

☐ None

_____

_____

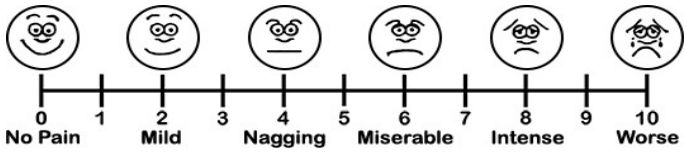
_____

_____

_____

_____

Rate your pain: Circle the number that best describes your pain right now



MEDICATIONS (Taken Regularly)

☐ Patient provided current medication list

Medication	Dosages	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Symptoms

Please check boxes to indicate if you have any of these problems, or if they have worsened in the last 6 to 12 months:

CARDIOLOGY
- ☐ Fainting or Loss of Consciousness
- ☐ Palpitations/Irregular Heart Beat
- ☐ Shortness of Breath when laying flat
- ☐ Swelling in the Legs or Hands

EYES
- ☐ Sudden vision changes or loss

GASTROINTESTINAL
- ☐ Abdominal Pain

GENERAL SYMPTOMS
- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ Weight Loss
- ☐ Weight Gain

HEAD, NOSE & THROAT
- ☐ Mouth or Gums bleeding
- ☐ Throat Pain

HEMATOLOGIC
- ☐ Blood Clots
- ☐ Easy Bruising

MUSKULOSKELETAL
- ☐ Back or Neck pain
- ☐ Joint Pain
- ☐ Joint Swelling

NEUROLOGICAL
- ☐ Change in Balance
- ☐ Changes in Speech
- ☐ Dizziness
- ☐ Headache
- ☐ Memory Problems
- ☐ Seizures

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

VASCULAR
- ☐ Hair Loss on Legs
- ☐ Non-Healing Wounds on Legs or Feet
- ☐ Pain, Cramping or Fatigue in Leg Muscles or Buttocks with Walking or Exertion
- ☐ Pain in Arm Muscles with Use

OTHER

_____

_____

_____

_____

_____

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Vascular Surgery

Patient Name: _____ Birthdate: _____

Supplemental Family Medical History

Please select any known family history of health problems:

	Diabetes	Heart Disease	Breast Cancer	Colon Cancer
Father	☐	☐	☐	☐
Mother	☐	☐	☐	☐

OTHER

_____

_____

SUPPLEMENTAL MEDICAL QUESTIONAIRE

Medical History: ***(Please select all that apply and specify any other medical conditions)***

- ☐ Anemia
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Chronic Kidney Disease
- ☐ COPD / Emphysema
- ☐ Diabetes
  [ ] Type 1 [ ] Type 2
  Controlled with [ ] Pills [ ] Insulin

- ☐ End Stage Renal Disease
  Dialysis Frequency:_____
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Seizure
- ☐ Sleep Apnea

OTHER:_____

_____

Supplemental Surgical History

Please select any of the surgeries you've had:

- ☐ Abdominal Aortic Aneurysm (AAA) Repair
- ☐ Amputation:_____
- ☐ AV Fistula Shunt/Graft: ( ) Left ( ) Right
- ☐ Back Surgery
- ☐ CABG/ Heart Bypass Surgery
- ☐ Cardiac Ablation
- ☐ Cardiac Stent: _____
- ☐ Carotid Endarterectomy
- ☐ Defibrillator Brand:_____
- ☐ Dialysis Catheter
- ☐ Female
  ( ) C-Section
  ( ) Mastectomy

- ☐ Hip Replacement: ( ) Left ( ) Right ( ) Both
- ☐ Kidney Removal: ( ) Left ( ) Right
- ☐ Kidney Transplant: ( ) Left ( ) Right
- ☐ Knee Replacement ( ) Left ( ) Right ( ) Both
- ☐ Leg Bypass
- ☐ Neck Surgery
- ☐ Pacemaker
- ☐ Peripheral Stent:_____
- ☐ Porta Cath
- ☐ Weight loss Surgery

OTHER:_____

_____

Patient Signature: *X*_____ Date: _____/ _____/ _____

Official use only: MRN#: _____ Account #: _____