MARYLAND VASCULAR SPECIALISTS
Compassionate. Innovative. Trusted.

SELF HISTORY

Name _____ Date of Birth _____

Reason for visit _____ Date _____

Pharmacy name _____ Phone _____

Preferred lab _____ Phone _____

Preferred imaging center _____ Phone _____

Height:	Weight:	Current pain level: 1 2 3 4 5 6 7 8 9 10

Allergies Check here if you have no known allergies ☐
Allergies to Medications: _____

Medications Please list any medications you take, Check here if none ☐
**If you have a separate list, please attach. We can return your copy at the front desk.

Name of Medication	Dose	How often do you take it?

Family History Check if any of your immediate family members have had the following illnesses.

	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Aneurysm:	☐	☐	☐	☐	Heart Disease:	☐	☐	☐	☐
Anemia/Bleeding:	☐	☐	☐	☐	High Blood Pressure:	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐	Kidney Disease:	☐	☐	☐	☐
Vascular Disease:	☐	☐	☐	☐	Diverticular/Crohn's:	☐	☐	☐	☐
Carotid Disease:	☐	☐	☐	☐	Diabetes:	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	Malignant Hyperthermia:	☐	☐	☐	☐

Specify type of Cancer: _____

Other Health issues that family members have had that we should know about: _____

Social History

Smokeless Tobacco Smoking Status:	☐ Never	☐ Former	☐ Everyday	☐ Somedays
E-cigarette/ Vape Status:	☐ Never	☐ Former	☐ Everyday	☐ Somedays

Advanced Directive *is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. There are two main types of advance directive — the "Living Will" and the "Durable Power of Attorney for Health Care."*

Do you have an Advanced Directive(s) in place? (Y/N) If Yes, please list below _____

Deaf or Serious difficulty Hearing? (Y/N) Blind or Serious difficulty Seeing? (Y/N)

Caffeine Intake:	☐ None	☐ Occasional	☐ Moderate	☐ Heavy

I have difficulty with the following:

☐ Concentrating ☐ Walking ☐ Doing Errands Alone ☐ Remembering
☐ Climbing Stairs ☐ Making Decisions ☐ Dressing ☐ Bathing

Ambulatory Questions:

☐ Walks without restrictions ☐ Limited self-mobility ☐ Confined to chai
☐ Dependent in wheelchair ☐ Walks with assistive device(s) ☐ Independent in wheelchair
☐ Unable to walk ☐ Bed-ridden

Do you currently live alone or with others?	(Yes / No)		

Tobacco Smoking Status: ☐ Never ☐ Former ☐ Everyday ☐ Somedays

Years of use: _____ How many packs a day? _____ What year did you quit? _____

Is a blood transfusion acceptable in the event of an emergency?	(Yes / No)	

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
What is current stress level? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Surgical History Check here if none ☐

Date	Procedure	Hospital	Doctor

Have you ever had a balloon procedure or stents in your heart, kidneys, abdomen, legs or arms? (Y/N) IF yes, please list the type of procedure and date. _____

Medical History
Circle all that apply to you.

Anemia	Coronary Artery Disease	Vascular Disease	Asthma
Aneurysm	Diabetes Type 1 Diabetes Type 2	GERD	Renal Failure
A-Fib	High Blood Pressure	Varicose Veins	Ulcers
Back Problems	Heart Attack	High Cholesterol	Thyroid Disease
DVT (blood clot)	Kidney Disease	Stroke/ TIA	Emphysema/ COPD
Cancer	Specify Type of Cancer:		
Other:		Other:	

Are you currently on dialysis? Yes or No
If yes, what are your dialysis days? _____
Name and phone number of center: _____

Do you have any painful sores or ulcers? Yes or No Do you go to Wound Care Center? Yes or No
If yes, where? _____

Have you recently been Hospitalized? Yes or No
If yes, where? _____
What was the reason you were in the Hospital? _____
_____

When you walk to do you experience aching, cramping or pain in your legs? Yes or No

If yes, when do you feel pain?
☐ After walking 1 block ☐ Climbing a flight of stairs ☐ After walking 100 yards ☐ Walking at increased speed

Have you had any of the following Ultrasounds,Cat scans or MRIs recently? (check all that apply to you)

Carotids (neck)	Abdomen	Legs

If yes, where and when were they done?
_____

My signature verifies that the information provided is correct to the best of my knowledge.
(If completed by someone other than the patient, please indicate your name and relationship to the patient.)

Patient _____

Signature _____ Date _____