SURGICAL ASSOCIATES
of Cleveland, P.C.
General and Vascular Surgery
Vein Treatment Center

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PATIENT HISTORY

NAME _____ DATE _____

HISTORY OF **MRSA INFECTION**? ❑ YES ❑ NO SIGNIFICANT **INJURIES**? ❑ YES ❑ NO WHEN? _____

DO YOU SEE A **PAIN MANAGEMENT** DOCTOR? ❑ YES ❑ NO NAME _____

PAST MEDICAL HISTORY

PLEASE CHECK IF **YOU** HAVE HAD ANY OF THE FOLLOWING:
IF PROBLEM IS NOT LISTED WRITE IN EMPTY SPACE OR UNDER "OTHER".

BLOOD DISORDER
- ❑ ANEMIA
- ❑ BLOOD CLOTS
- ❑ EASY BLEEDING

CARDIOVASCULAR DISORDER
- ❑ CORONARY ARTERY DISEASE
- ❑ HEART ATTACK
- ❑ CONGESTIVE HEART FAILURE
- ❑ HIGH BLOOD PRESSURE
- ❑ ATRIAL FIBRILLATION
- ❑ HIGH CHOLESTEROL

❑ **CHRONIC PAIN**

ENDOCRINE DISORDER
- ❑ DIABETES
- ❑ THYROID DISORDER

EAR/NOSE/THROAT DISORDER
- ❑ HEARING LOSS

EYE DISORDER
- ❑ GLAUCOMA

GASTROINTESTINAL DISORDER
- ❑ ACID REFLUX
- ❑ ULCER DISEASE
- ❑ LIVER DISEASE
- ❑ CROHN'S DISEASE
- ❑ DIVERTICULOSIS
- ❑ IRRITABLE BOWEL SYNDROME

NEUROLOGIC DISORDER
- ❑ SEIZURE DISORDER
- ❑ STROKE
- ❑ DEMENTIA

ORTHOPEDIC (BONE) DISORDER
- ❑ OSTEOPOROSIS
- ❑ OSTEOARTHRITIS
- ❑ GOUT

PSYCHIATRIC DISORDER
- ❑ ANXIETY DISORDER
- ❑ DEPRESSION

KIDNEY DISEASE
- ❑ KIDNEY STONE
- ❑ KIDNEY FAILURE
- ❑ DIALYSIS ❑ YES ❑ NO
  DAYS_____

RESPIRATORY DISORDER
- ❑ ASTHMA
- ❑ COPD

❑ **SKIN DISORDER**

RHEUMATOLOGY DISORDER
- ❑ RHEUMATOID ARTHRITIS
- ❑ FIBROMYALGIA

UROLOGIC DISORDER
- ❑ PROSTATE DISORDER

GYNECOLOGIC DISORDER
- ❑ OVARIAN CYSTS
- ❑ ENDOMETRIOSIS

OB HISTORY
OF PREGNANCIES _____
OF BIRTHS _____
CAESAREAN SECTION ❑ YES ❑ NO

OTHER
_____
_____
_____

CANCER
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ❑ YES ❑ NO

IF YES, WHAT KIND OF CANCER AND WHEN? _____
_____
_____
_____

SURGICAL HISTORY

HAVE YOU EVER HAD SURGERY? ❑ YES ❑ NO

IF YES, PLEASE LIST THE OPERATIONS YOU HAD AND THE YEAR EACH OCCURRED: _____

_____

_____

_____

CONTINUED ON OTHER SIDE

PATIENT NAME _____ DATE _____

FAMILY HISTORY

PLEASE CHECK IF A BLOOD RELATIVE HAS HAD ANY OF THE DISEASES OR CONDITIONS BELOW:

❑ NO SIGNIFICANT FAMILY HISTORY

❑ ALCOHOLISM
❑ AUTO IMMUNE DISEASE
❑ BLEEDING DISORDER
❑ DIABETES
❑ HEART DISEASE
❑ HIGH CHOLESTEROL
❑ HIGH BLOOD PRESSURE
❑ LIVER DISEASE
❑ REACTION TO ANESTHESIA
❑ KIDNEY DISEASE
❑ STROKE
❑ BLOOD CLOT
❑ THYROID DISEASE
❑ OTHER _____

MOTHER DECEASED ❑ YES, AT AGE _____ CAUSE _____

FATHER DECEASED ❑ YES, AT AGE _____ CAUSE _____

HAS ANY BLOOD RELATIVE HAD CANCER? ❑ YES ❑ NO

IF YES, LIST WHICH RELATIVE AND WHAT TYPE OF CANCER _____

_____

_____

SOCIAL HISTORY

OCCUPATION: _____ ❑ UNEMPLOYED ❑ DISABLED ❑ RETIRED

LIVING SITUATION: ❑ ALONE ❑ WITH SPOUSE ❑ WITH OTHER ❑ NURSING HOME

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

ALCOHOL USE:
❑ NEVER DRANK ALCOHOL
❑ STOPPED DRINKING ALCOHOL
❑ 2 DRINKS/DAY OR FEWER
❑ MORE THAN 2 DRINKS/DAY

TOBACCO USE:
PREVIOUS SMOKER ❑ YES ❑ NO _____ PACKS/DAY _____ YEARS
PRESENTLY SMOKING ❑ YES ❑ NO _____ PACKS/DAY _____ YEARS
CHEWS TOBACCO ❑ YES ❑ NO

RECREATIONAL DRUGS DRUG USE NOW ❑ YES ❑ NO
RECOVERING FROM DRUG ADDICTION ❑ YES ❑ NO

CAFFEINE USE: ❑ YES ❑ NO AMOUNT/DAY _____