Vascular Institute of Virginia
14085 Crown Court
Woodbridge, VA 22193
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FOR OFFICE USE ONLY

MEDICAL QUESTIONNAIRE

Name: _____

Age: _____

Sex: ☐ Male ☐ Female

Do you have any general allergies or allergies to medications? Yes No

If yes, please list and describe reaction:_____

_____

_____

List all previous surgeries:_____

_____

_____

_____

List all current medications:_____

_____

_____

_____

_____

_____

Do you smoke? No Yes How much? How long?

Do you drink alcohol? No Yes # Drinks/day:

Do you use marijuana, cocaine, or other recreational drugs? No Yes

Do you use a: ☐ cane? ☐ walker? ☐ wheelchair?

Are you or could you be pregnant? Yes No

Date of your last menstrual cycle: _____

Do you, or have you ever had cancer? Yes No Type?_____

Do you have a family history of cancer? No Yes

If yes, what family member and what type? _____

REVIEW OF SYSTEMS

Do you have any problems now or have you had any related to the following systems? Indicate Yes or No

GENERAL HEALTH	YES	NO
Dentures	○	○
Glasses/Contacts	○	○
Hard of Hearing	○	○
HEIGHT: WEIGHT:		

EYES		
Glaucoma	○	○
Cataracts	○	○

CARDIOVASCULAR		
Open Heart Surgery Type:		
High Blood Pressure		
Chest Pain	○	○
Heart Attack	○	○
Irregular Heartbeat	○	○
Heart Murmur	○	○
Pacemaker	○	○
Defribrillator	○	○
Congestive Heart Failure	○	○
Mitral Valve Prolapse	○	○
Rheumatic Fever	○	○
Peripheral Arterial Disease (PAD)	○	○

PSYCHOLOGICAL		
Anxiety	○	○
Depression	○	○
Other:		

GENITOURINARY		
Blood in Urine	○	○
Nocturia (getting up at night)	○	○
Urinary Frequency (>8 times/day)	○	○
Urinary Tract Infection	○	○
Urinary Leakage	○	○
Kidney Stones	○	○
Kidney Disease	○	○
Dialysis Days?	○	○
Comments:		

ENDOCRINE		
Diabetes	○	○
Thyroid Condition	○	○
Comments:		

MUSCULOSKELETAL	YES	NO
Muscle Weakness	○	○
Joint Pain (Swelling)	○	○
Arthritis	○	○
History of Orthopedic Surgery	○	○
Chronic Back Pain/Injury	○	○
Chronic Neck Pain/Injury	○	○
Comments:		

NEUROLOGICAL		
Tremors	○	○
Dizzy Spells	○	○
Numbness/Tingling	○	○
Stroke	○	○
Seizures	○	○
TIA's	○	○
Comments:		

HEMATOLOGIC/LYMPHATIC		
Blood Clotting Problem	○	○
Easy Bleeding/Bruising	○	○
Anemia	○	○
Sickle Cell Trait or Disease	○	○
Enlarged Lymph Nodes	○	○
Blood Transfusion History	○	○
Immune Deficiency	○	○
Hepatitis Type:	○	○
HIV	○	○

RESPIRATORY		
Asthma/COPD	○	○
Chronic Cough	○	○
Shortness of Breath	○	○
Emphysema	○	○
Exposure to Tuberculosis	○	○
Pneumonia	○	○
Bronchitis	○	○
Sleep Apnea/CPAP use	○	○
Comments?		

GASTROINTESTINAL		
Abdominal Pain	○	○
Nausea/Vomiting	○	○
Indigestion/Heartburn /GERD	○	○
Constipation	○	○
Diarrhea	○	○
Bloody or Dark Stools	○	○
Ostomy Bag	○	○
Comments:		