NEOVA
NORTHEAST OHIO VASCULAR ASSOCIATES, INC.

PAST MEDICAL/SURGICAL HISTORY

CHECK ALL THAT APPLY INCLUDING DATE OF OCCURENCE:

PAST MEDICAL HISTORY

Name _____

Date of Birth _____

	Date
❑ No Medical Problems	
❑ Obesity	
❑ High Blood Pressure (Hypertension)	
❑ Heart Artery Blockage (Coronary artery disease)	
❑ Past Heart Attack (Myocardial infarction)	
❑ Heart Failure (Congestive heart failure)	
❑ Heart Murmur	
❑ Heart Pain (Angina)	
❑ Heart arrhythmia (Atrial fibrillation)	
❑ High Cholesterol	
❑ Sugar Diabetes	
❑ Diabetes (Childhood)	
❑ Deep Vein Blood Clots (DVT)	
❑ Superficial Blood Clots	
❑ Varicose Veins	
❑ Spider Veins	
❑ Blood Clotting Disorder	
❑ Factor 5 Leiden	
❑ Taking Blood thinners	
❑ Bleeding Tendency	
❑ Blood Clot to Lung (Pulmonary Embolis)	
❑ AIDS (HIV)	
❑ Lymphoma	
❑ Leukemia	
❑ Multiple Myeloma	
❑ Hodgkin's Disease	
❑ Stroke	
❑ TIA (Mini-stroke)	
❑ Neuropathy	
❑ Peripheral Artery Disease (PAD)	
❑ GERD (Gastroesophageal Reflux)	
❑ Thyroid Problems (Hyper/Hypothyroid)	

❑ Liver Problems	
❑ Dialysis (Days M W F T TS)	
❑ Hepatitis A B C	
❑ COPD (Lung Disease)	
❑ Asthma	
❑ Chronic Bronchitis	
❑ Pneumonia	
❑ Kidney Problems	
❑ Renal failure (Kidney Failure)	
❑ Urine Infections (UTI)	
❑ Cancer	
❑ Seizures	
❑ Enlarged Prostate	
❑ Arthritis	
❑ Rheumatoid arthritis	
❑ Lupus/Scleroderma/Polymyalgia Rheumatica/Temporal Arteritis	
❑ Seasonal allergies	
❑ Blindness	
❑ Psoriasis	
❑ Leg ulcers	
❑ Foot ulcers	
❑ Finger ulcers	
❑ Low back pain	
❑ Trauma requiring hospitalization	
❑ Leg Swelling (Edema)	
❑ Pregnancy	
❑ Radiation Therapy	
❑ Leg or Arm cellulitis	
❑ Diverticulosis/Diverticulitis	
❑ Pancreatitis	
❑ Stomach Ulcer	
❑ Esophagitis	
❑ Anemia	
❑ Blood Transfusion	
❑ Marfan's Syndrome	
❑ Ehler's-Danlos Syndrome	
❑ Abdominal Aortic Aneurysm	
❑ Other:	

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Name: _____

PAST SURGICAL HISTORY

	Date
❑ No Previous Surgeries	
❑ Fistula/Graft	
❑ Artery balloon angioplasty/stent leg or abdomen	
❑ Artery bypass leg	
❑ Artery bypass abdomen	
❑ Carotid Artery Surgery (Endarterectomy)	
❑ Carotid Artery Stent	
❑ CABG (Coronary Artery Bypass)	
❑ Heart Valve replacement	
❑ Screen in abdomen Vein (IVC Filter)	
❑ Vein Surgery/Vein Stripping	
❑ Vein Injection (Sclerotherapy)	
❑ Spine surgery of Back	
❑ Spine surgery of Neck	
❑ (AAA/EVAR) Abdominal Aortic Aneurysm	
❑ Open (AAA) Abdominal Aortic Aneurysm Repair	
❑ Heart (Cardiac) Catheterization)	
❑ Hysterectomy	
❑ Amputation (what)	
❑ Appendix removal (Appendectomy)	
❑ Gallbladder Surgery (Cholecystectomy)	
❑ Colon, Stomach, Pancreas Surgery	
❑ Kidney/Bladder surgery	
❑ Prostate Surgery	
❑ Breast Surgery	
❑ Cancer Surgery (what)	
❑ Lung Surgery	
❑ Foot/Leg fracture surgery	
❑ Arm Fracture Surgery	
❑ Hip fracture surgery	
❑ Total Hip Replacement	
❑ Total Knee replacement	
❑ Heart Angioplasty/stent	
❑ Other	

FAMILY HISTORY

	Mom	Dad	Sister/ Brother
Abdominal aortic aneurysm (AAA)	☐	☐	☐
Alcohol abuse	☐	☐	☐
Asthma	☐	☐	☐
Bleeding tendency	☐	☐	☐
Heart disease	☐	☐	☐
Deep vein thrombosis (DVT)	☐	☐	☐
Sugar Diabetes	☐	☐	☐
High Cholesterol	☐	☐	☐
High Triglycerides	☐	☐	☐
High Blood Pressure (Hypertension)	☐	☐	☐
Lung Blood Clot (Pulmonary embolism)	☐	☐	☐
Stroke	☐	☐	☐
Clotted superficial veins	☐	☐	☐
Clotting Disorders	☐	☐	☐
Varicose veins	☐	☐	☐
Cancer	☐	☐	☐
Factor 5 Leiden Vasculitis	☐	☐	☐

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Name: _____

ALLERGIES

- ❑ No known allergies
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Sulfa
- ❑ Morphine
- ❑ Erythromycin
- ❑ Codeine
- ❑ Iodine/Betadine
- ❑ Radiographic dyes (IVP dye)
- ❑ Adhesive Tape
- ❑ Shellfish
- ❑ Other (specify)

Flu Shot:

- ❑ Yes: Day____ Month_____ Year_____
- ❑ No

Pneumonia Shot:

- ❑ Yes: Day____ Month_____ Year_____
- ❑ No

SOCIAL HISTORY

- ❑ I am a non-smoker
- ❑ Yes, I currently smoke cigarettes

I smoke 1 2 3 packs per day
I have smoked for _____ years
No, but I used to smoke. Year quit ____
I smoked for ___ years, ___ packs per day
Yes, I am a cigar smoker. I smoked for ____ years and ____ per day

- ❑ Unknown if ever smoked
- ❑ I am a non-drinker

My drinking habits are:

- ❑ Heavy
- ❑ Social
- ❑ Moderate
- ❑ Quite Heavy
- ❑ Reformed alcoholic since _____
- ❑ I consume:

Liquor_____ shots per _____(day/week)
Beer _____ beers per _____(day/week)
Wine_____ glasses per____(day/week)

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CHECK ALL THAT APPLY INCLUDING DATE OF OCCURENCE:

PATIENT MEDICATIONS

Date:_____

Patient Name:_____**Date of Birth:**_____

Pharmacy Name:_____**Phone Number:**_____

What medications are you currently taking: Please list both prescription and non-prescription, or please attach list.

Medication:	**Dose:**	**Number of times taken per day:**