MINNEAPOLIS HEART INSTITUTE
Abbott Northwestern's Vascular Center & Vascular Specialists of MN
(612) 863-6800 (800) 582-5175
www.mplsheart.com/vascular

Appt. Date: _____

Dr: _____

NAME: _____ **DATE:** _____
DATE OF BIRTH: _____
Spouse/Significant Other Name: _____ Relationship: _____

Your Primary Physician: _____
Address: _____
City, State and Zip: _____Telephone: _____

Physician who referred you today (if different from Primary Physician):_____
Address: _____
City, State and Zip: _____Telephone: _____

Reason for visit today: _____

RISK FACTORS

1. Do you have high blood pressure or ever been treated for high blood pressure? Yes ☐ No ☐ Unknown ☐
   If yes, give the length of time: _____
   If yes, are you taking medication to lower your blood pressure? Yes ☐ No ☐
   What is the name of this medication? _____
   Do you monitor your blood pressure? Yes ☐ No ☐
   Do you know your blood pressure goal? Yes ☐ No ☐
   If yes, what is your goal?: _____

2. Have you ever had elevated cholesterol or blood fats? Yes ☐ No ☐ Unknown ☐
   If yes, give length of time: _____
   If yes, are you taking medication for this? Yes ☐ No ☐
   What is the name of this medication? _____

3. Do you exercise regularly? Yes ☐ No ☐ Unknown ☐
   If yes, please indicate which activities you routinely participate in and the amount of time:

Activity	Frequency / week	Duration (minutes)
Walk	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Bike	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Swim	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Jog	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Run	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Stairs	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Treadmill	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Nordic Track	0 1 2 3 4 5 6 7	<10 <15 30 45 >45
Cardiac Rehab	0 1 2 3 4 5 6 7	<10 <15 30 45 >45

Do you use any home exercise equipment? Yes ☐ No ☐ Unknown ☐
If yes, what equipment do you use? ?_____

4. Rank your overall stress level by circling the appropriate number below using a scale from 1-10, 1 being low to minimal stress and 10 being the greatest amount of stress.

0 1 2 3 4 5 6 7 8 9 10

Is your stress manageable? Yes ☐ No ☐

What are your stressors? Family ☐ Occupation ☐ Financial ☐ Medical ☐

5. How much of the following do you consume daily?

	Cups
Caffeine (coffee, colas)	0 1 2 3 4 5 6 or more
Alcohol	0 <1 1 2 3 or more

6. Do you currently smoke or are you a former smoker? Yes ☐ No ☐ Unknown ☐

If yes,

Do you smoke cigarettes?	Yes ☐ No ☐
Do you smoke cigars?	Yes ☐ No ☐
Do you chew smokeless tobacco?	Yes ☐ No ☐
# of packs/day (circle)	<1 1 1 ½ 2 or more
# of years smoked	
Year smoking started	
Year smoking stopped	

Have you ever been given advice to quit smoking? Yes ☐ No ☐ Unknown ☐

7. Do you or have you ever-used illicit or street drugs? Yes ☐ No ☐

If yes, please indicate type: If Yes: Now ☐ In the Past ☐

- ☐ Marijuana
- ☐ Cocaine
- ☐ Amphetamines
- ☐ Hallucinogens
- ☐ Sedatives
- ☐ Weight Loss medications

ALLERGIES

1. Do you have any allergies to medications or food? Yes ☐ No ☐

   If yes, which ones: _____

2. Have you ever received contrast or dye for an Xray or test? Yes ☐ No ☐

   If yes, did you have any side effects? Yes ☐ No ☐

3. Have you had asthma? Yes ☐ No ☐
4. Have you had hives? Yes ☐ No ☐

   From what (iodine, shellfish, etc.)? _____

MEDICATIONS

Please list your current medications. Be sure to include any over-the-counter medications, vitamins and herbal/dietary supplements or weight control medications.

NAME	DOSAGE	FREQUENCY

8. Is there any history of vascular or heart disease in your family? Yes ☐ No ☐ Unknown ☐
(Definition: First-degree male relative under age 55 or female relative under age 65)

Is there any history of the following in your family:

- Stroke/TIA Yes ☐ No ☐ Unknown ☐
- Abdominal aortic aneurysms Yes ☐ No ☐ Unknown ☐
- Leg artery bypass Yes ☐ No ☐ Unknown ☐
- Leg angioplasty/angiogram with stent Yes ☐ No ☐ Unknown ☐
- Leg amputations Yes ☐ No ☐ Unknown ☐
- Heart disease Yes ☐ No ☐ Unknown ☐
  - Heart attack Yes ☐ No ☐ Unknown ☐
  - Coronary artery bypass Yes ☐ No ☐ Unknown ☐
  - Angiography with stent placement Yes ☐ No ☐ Unknown ☐
  - Valve replacement Yes ☐ No ☐ Unknown ☐

9. Have you ever had diabetes? Yes ☐ No ☐ Unknown ☐
If yes, give length of time: _____

SOCIAL HISTORY

10. Are you retired? Yes ☐ No ☐
If yes, when did you retire? _____

11. What is/was your occupation(s)? _____

12. What is the highest level of education you completed?
Grade school ☐ High school ☐ College ☐ Post Graduate ☐

FAMILY HISTORY

	Age, if living	Current Health Status	Age and Cause of Death
Father			
Mother			
Brothers:			
Sisters:			

Spouse:			
Children:			

PAST MEDICAL and SURGICAL HISTORY

Please list any chronic or acute diseases/diagnosis that you have been found to have. Also, list any surgeries that you have undergone.

DIAGNOSIS or SURGERY	HOSPITAL	DATE

Have you ever had a blood transfusion? Yes ☐ No ☐
Have you ever had a reaction to a blood transfusion? Yes ☐ No ☐

REVIEW OF SYSTEMS

1. *General:*
   Have you been experiencing: ☐ Fever ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Chills ☐ Sweats ☐ Appetite Loss

2. *Eyes*
   Do you have: ☐ Blurred vision ☐ Cataracts ☐ Eye Irritation ☐ Eye redness ☐ Corrective lenses ☐ Glaucoma ☐ Light Sensitivity ☐ Halos around lights ☐ Double Vision ☐ Eye Pain ☐ Eye Discharge ☐ Vision Loss: ☐ One Eye ☐ Both Eyes

3. *Ears/Nose/Throat*
   Do you have: ☐ Decreased hearing ☐ Poor dental hygiene ☐ Ear Discharge ☐ Sore Throat ☐ Hoarseness ☐ Nosebleeds ☐ Difficulty swallowing ☐ Snoring ☐ Ringing in ears ☐ Ear Ache ☐ Nasal Congestion

4. *Cardiovascular*
   Do you have: ☐ Chest pain/discomfort ☐ Leg cramps with exertion ☐ Trouble breathing lying down ☐ Lightheadedness ☐ Palpitations ☐ Trouble breathing at night ☐ Fainting ☐ Swelling of hands or feet ☐ Racing or skipping heart ☐ Bluish Discoloration of nails/lips ☐ Shortness of breath with exertion

5. *Vascular*
   Do you have:
   1. Any difficulty walking (pain, numbness, fatigue, cramping) in your calves, buttocks, or thighs? Yes ☐ No ☐
      How far can you walk before symptoms begin?: _____
      Does it subside with rest? Yes ☐ No ☐
   2. Any poorly healing or nonhealing wounds of the legs or feet. Yes ☐ No ☐
      How long have these been present? _____
   3. Any pain in your lower legs or feet at rest (lying flat)? Yes ☐ No ☐
      Does your pain subside when you are upright? Yes ☐ No ☐
   4. Do you have abdominal pain after a meal? Yes ☐ No ☐
      Have you lost weight even though you're eating? Yes ☐ No ☐

a. Do you have a first degree relative (mother, father, sister, brother) with an abdominal aortic aneurysm (AAA)? Yes ☐ No ☐

6. *Respiratory*

Do you have:
☐ Asthma ☐ COPD (lung disease) ☐ Coughing up blood ☐ Excessive sputum
☐ Cough ☐ Chest discomfort ☐ Sleep disturbance due to breathing
☐ Wheezing ☐ Shortness of breath ☐ Excessive snoring

7. Gastrointestinal

Do you have:
☐ Abdominal pain ☐ Change in bowel habits ☐ Constipation ☐ Gas
☐ Diarrhea ☐ Dark tarry stools ☐ Vomit blood ☐ Heartburn
☐ Yellow skin or eyes ☐ Blood in stool ☐ Nausea ☐ Indigestion
☐ Rectal bleeding ☐ Ulcer disease ☐ Vomiting
☐ Excessive Bloating ☐ Abdominal bloating ☐ Hemorrhoids

8. Genitourinary

Do you have:
☐ Pain on urination ☐ Blood in urine ☐ Urinary Urgency
☐ Urinary frequency ☐ Trouble starting stream ☐ Night time urination
☐ Incontinence ☐ Decreased sex drive ☐ Erectile dysfunction
☐ Genital Sores ☐ Unusual color of urine ☐ Inability to empty bladder
☐ Kidney Pain ☐ Pelvic pain ☐ Foul urinary discharge
☐ Missed Periods ☐ Excessively heavy periods

9. Musculoskeletal

Do you have:
☐ Arthritis/joint swelling ☐ Stiffness ☐ Gout ☐ Muscle weakness

10. Skin

Do you have:
☐ Dryness ☐ Itching
☐ Lesions ☐ Nodules
☐ Open sores ☐ Rash

11. Neurologic

Do you have:
☐ CVA (stroke) ☐ Headaches
☐ Tremors ☐ Difficulty with speech
☐ Numbness/tingling ☐ Seizures
☐ Vertigo ☐ Weakness
☐ Dizziness ☐ Memory Loss

12. Psychiatric

Do you have:
☐ Anxiety ☐ Depression
☐ Mental Disturbance ☐ Suicidal ideation

13. Endocrine

Do you have:
☐ Cold intolerance ☐ Diabetes Mellitus
☐ Heat intolerance ☐ Polydipsia (thirsty)
☐ Polyuria (urination in large amts) ☐ Thyroid disease
☐ Weight change

13. Heme/Lymphatic

Do you have:
☐ Abnormal bruising ☐ Bleeding disorder
☐ Clotting disorder ☐ Enlarged lymph nodes

14. Allergic/Immunologic

Do you have:
☐ Hives ☐ Hay fever
☐ Persistent infections ☐ HIV exposure

LEARNING STYLE

1. Identified Learning Barriers:
☐ None ☐ Reading Ability
☐ Sensory Problem(s) ☐ Emotional State
☐ Cultural/Religious Practice ☐ Other _____
☐ Pain

2. Communication Barriers:

- ☐ Language other than English
- ☐ Speech/Hearing Impaired
- ☐ Vision Impaired
- ☐ Change in memory status
  - ☐ Long Term ☐ Short Term ☐ Immediate Recall

(immediate = within last hour/Short Term = within week/Long Term = over one year)

---

1. Preferred Style of Learning:

What is the easiest way for you to learn?

- ☐ Listening ☐ Reading
- ☐ Pictures/Video ☐ Demonstration
- ☐ Other _____
- ☐ Needs caretaker to receive education
  Who? _____