General *Vascular* Surgery MEDICAL GROUP

Patient Profile Form

Printing and completing this form in the comfort of your own home allows us to assist you promptly and efficiently when you arrive for your appointment. Your honesty and accuracy in completing this form are essential to our ability to properly assist you.

Please describe the problem which prompted you to contact GVS.

How long has this been affecting you? _____

Are you currently taking any medicines that thin the blood *(including aspirin and Plavix)*? _____

Are you allergic to Penicillin? Yes/No

Do you have any other allergies to medications? _____ **If yes, please list below:**

Please list all prior operations you have had, with approximate year of procedure:

Procedure	Date
Procedure	Date
Procedure	Date
Procedure	Date

Please list any medical problems experienced by your immediate family, including parents, siblings, and children:

Please indicate if you suffer from:

- ❑ High blood pressure
- ❑ Stroke or mini-stroke
- ❑ Leg cramps while walking
- ❑ Blood clots in legs
- ❑ Swelling in legs
- ❑ Heart attack
- ❑ Aneurysm
- ❑ Angina
- ❑ Seizures
- ❑ Nerve problems
- ❑ Lung disorders, including asthma, bronchitis, and emphysema
- ❑ Shortness of breath
- ❑ Liver problems or hepatitis
- ❑ Kidney problems
- ❑ Stomach or intestinal problems
- ❑ Bone/joint problems or gout

Do you have a history of other medical problems not listed above? If so, please list: