



Vascular Worksheet

Please circle as appropriate

Name:

Past History:

- | | | | | | | |
|-----|-----------------------------|--------|-----------------|-----------|-------|--------------|
| 1) | Heart | Angina | Irregularity | Failure | Valve | Heart attack |
| 2) | High blood pressure | | | | | |
| 3) | High Cholesterol | | | | | |
| 4) | Diabetes | | | | | |
| 5) | Respiratory | Asthma | Chest infection | Emphysema | | |
| 6) | Kidney | | | | | |
| 7) | Deep vein thrombosis | | | | | |
| 8) | Pulmonary embolism | | | | | |
| 9) | Arthritis | | | | | |
| 10) | Strokes | | | | | |

Surgery:

Allergies:

Medications:

- | | |
|----|----|
| 1) | 5) |
| 2) | 6) |
| 3) | 7) |
| 4) | 8) |

Family history:

High blood pressure	Diabetes
Clotting	Bleeding
Strokes	

Personal:

Smoking	per/day	How long
Alcohol	per/day	How long
Occupation		