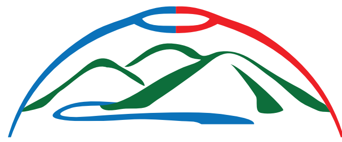

WILLAMETTE
VASCULAR SPECIALISTS, P.C.

FAMILY MEDICAL HISTORY (blood relatives only)

		CONDITION	RELATIONSHIP			CONDITION	RELATIONSHIP
Yes	No	**Heart Disease**		Yes	No	**High Blood Pressure**	
Yes	No	**Diabetes**		Yes	No	**Varicose Veins**	
Yes	No	**Cancer - Type:**		Yes	No	**Blood Clots**	
Yes	No	**Stroke**		Yes	No	**Aneurysm**	

SOCIAL HISTORY

Tobacco: (circle) Never / Now / Past

Type: (circle) Cigarettes / Chew / Pipe / Cigars

How long have you or did you smoke for? ________

How many packs per day? _________

Date you quit? _________

If still smoking, do you have plans to quit? ________

Alcohol: (circle one) None / Rare / Daily / Weekly

How many drinks do you have per day________or week_________

Has alcohol been a problem in the past? (circle) Yes / No

Do you use any other substances? (circle) Yes / No

If so, please list: __________________________________

Living Situation: (circle all that apply)

Your Home / Assisted Living / Alone / With Family, Friends

Children: How many?_______________Ages:____________

NAME: ____________________________________ DATE:______________________________________