Pulse Vascular

994 West Sherman Ave. Unit 2
Vineland, NJ 08360

Office: 631-LEG PAIN
Mobile: 631-806-9445
Fax: 856-457-5681

www.drscotthollander.com
www.thesavinglimbsfoundation.org
shollander@pulse-vascular.com

Patient Name:
SSI:

Medical Questionnaire

Please take a few minutes to complete this questionnaire. Accurate information will help us in evaluating your medical status and taking care of your medical needs.

What is the name of your Nephrologist and Dialysis Center? _____

Age:_____ Sex: Male ☐ Female ☐

Race: African American ☐ Asian ☐ White ☐ Other: ☐ _____

Are you Hispanic? Yes ☐ No ☐

If 'Yes', please specify:

Mexican ☐ Puerto Rican ☐ Cuban ☐ Central American ☐ South American ☐

Do you have any general allergies or allergies to medicine? Yes ☐ No ☐

Please specify if 'Yes'

_____

_____

_____

Is there any chance of pregnancy? Yes ☐ No ☐ N/ A ☐ Last menstrual period: _____

Do you have Diabetes? Yes ☐ No ☐

Have you ever had Hepatitis? Yes ☐ No ☐

Do you have an Advanced Directive? Yes ☐ No ☐

Would you like information on Advanced Directive? Yes ☐ No ☐

What medications are you currently taking?

_____

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What medications have you taken today?

_____

When did you last eat or drink? _____

Did you receive a flu shot this year? No ☐ Yes ☐ Date _____

Have you received the pneumonia vaccine? No ☐ Yes ☐ Date _____

Have you received the COVID-19 vaccine No ☐ Yes ☐ Date of 2nd? _____

Which vaccine? _____

Have you had any of the following problems with your **HEART** or **CIRCULATION**?

Heart Murmur/Mitral valve prolapse	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Shortness of breath with rest or exercise	Yes ☐	No ☐
Chest pain with rest of exercise	Yes ☐	No ☐
Open Heart Surgery	Yes ☐	No ☐
Irregular heartbeat	Yes ☐	No ☐
Heart Failure	Yes ☐	No ☐
Difficulty with stairs	Yes ☐	No ☐
Ankle swelling	Yes ☐	No ☐

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Heart attack	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐

Have you had any of the following problems with your **BLOOD**? ☐

Bleeding tendency or easy bruising	Yes ☐	No ☐
Blood Transfusion	Yes ☐	No ☐
Sickle cell disease	Yes ☐	No ☐
Sickle cell trait	Yes ☐	No ☐

Explanation of any '**Yes**' Response: _____

_____

_____

Have you had any of the following problems with your **LUNGS** or **BREATHING**?

Asthma	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐
Cough or coughing up phlegm	Yes ☐	No ☐
Abnormal chest x-ray	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐
Shortness of breath	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐

Explanation of any '**Yes**' Response: _____

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What caused your **KIDNEYS** to stop working? _____

_____

Have you had any of the following problems with your **NERVES, MUSCLES,** or **BONES**?

Seizures	Yes ☐	No ☐
Head, Neck or Back injury	Yes ☐	No ☐
Extreme nervousness or anxiety	Yes ☐	No ☐
Fainting spells or stroke	Yes ☐	No ☐
Muscle weakness	Yes ☐	No ☐
Psychiatric illness	Yes ☐	No ☐

Explanation of any '**Yes**' Response: _____

_____

_____

Do you smoke?	Yes ☐	No ☐	How much?____How long? ____
Do you drink alcohol?	Yes ☐	No ☐	How much?____How long? ____
Do you use marijuana, cocaine, or any drugs including herbal or holistic drugs?	Yes ☐	No ☐	How much?____How long? ____

Have you had any of the following?

Dentures (permanent or removeable)?	Yes ☐	No ☐
Problems with hearing?	Yes ☐	No ☐
Glasses or contact lenses?	Yes ☐	No ☐

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Other vision problems? Yes ☐ No ☐

Explanation of any '**Yes**' Response: _____

_____

What hospital do you use? _____

_____

Have you seen other vascular providers? Yes ☐ No ☐

Pain level in legs? 1 2 3 4 5 6 7 8 9 10

How long have been suffering? _____

Are you taking pain medications because of your leg symptoms? Yes ☐ No ☐

If so, what are you taking? _____

Patient's Signature: _____ Date: _____