Appendix

PATIENT HISTORY FORM

All three forms presented here can be downloaded as a pdf from www.cirse.org

Use this form for patients seen in your office -
ask them to complete this form in the waiting room and review it with them during the exam.

Patient Health History

Patient Name: ---------- Date of birth: ----------

Address: ----------

Chief Complaint
Reason for today´s visit: ----------

History of Chief Complaint

Past Medical History
Please list any prior major illnesses and / or injuries.

Surgeries / Hospitalisations	*Year*	*Complications*

Have you ever had problems with anaesthesia? ○ Yes ○ No

Current Medication(s)	*Dose*	*Frequency*

Allergies to medications: ----------

Other allergies: ----------

Is there a family history of disease? ----------

Social History

Occupation: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Do you have any children? ○ Yes ○ No How many? _____

Do you live alone? ○ Yes ○ No Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

○ Yes, I smoke cigars or a pipe
○ No, I have never smoked
○ No, I stopped _____ years ago. At the time I was smoking _____ packs a day for _____ years.

Do you drink alcohol? ○ No never (or rarely) ○ No I used to
○ Yes ○ Daily ○ 1 or more times a week ○ or more times a month

Are you at risk for HIV/AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?
○ No ○ Yes (the physician will discuss with you during your visit)

Review of Systems

Are you currently having, or have you had, problems with:

Constitutional	**Circle one**	
Fever	Yes	No
Weight loss	Yes	No
Excessive fatigue	Yes	No
Night sweats	Yes	No
Cardiovascular/vascular		
Chest pain or angina - date of last ECG _____	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in feet or hands	Yes	No
Leg pain while walking	Yes	No
Leg pain at rest	Yes	No
Leg/foot ulcers or gangrene	Yes	No
Respiratory		
Asthma	Yes	No
Chronic cough	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody sputum	Yes	No
Date of last chest x-ray _____	Yes	No

Gastrointestinal

Indigestion or pain with eating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Ye	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in your bowel habits	Yes	No
Ulcers or gastritis	Yes	No
Colon cancer	Yes	No

Genitourinary

Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficulty starting or stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Prostate cancer (males)	Yes	No
Endometriosis (females)	Yes	No
Uterine or cervical cancer (females)	Yes	No

Musculoskeletal

Broken bones - list _____	Yes	No
Arm or leg weakness	Yes	No
Back pain	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No

Integumentary

Skin disease	Yes	No
Skin cancer	Yes	No
Breast pain, tenderness or swelling (females)	Yes	No
Nipple discharge (females	Yes	No
Date and result of last mammogram (females) _____		

Neurological

Fainting spells or "blacking out"	Yes	No
Seizures	Yes	No
Difficulty with your speech	Yes	No
Double or blurred vision	Yes	No
Face weakness	Yes	No
Coordination in arm and/or legs	Yes	No

Eyes, ear, nose, throat and mouth

Poor eyesight	Yes	No
Why? _____		
Glaucoma	Yes	No
Hearing loss	Yes	No
Ear infections	Yes	No
Balance disturbance (eg vertigo, spinning)	Yes	No
Nosebleeds	Yes	No
Nasal congestion or excessive drainage	Yes	No
Sinus problems	Yes	No
Sore throat	Yes	No

Mouth sores	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other psychiatric disorder/treatment _____		
Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst or urination	Yes	No
Hormone problems	Yes	No
Hematological/lymphatic		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding tendencies	Yes	No
Persistent swollen glands or lymph nodes	Yes	No
Blood transfusion. If yes, when? _____	Yes	No
Allergic/immunology		
Food allergies	Yes	No
Inhalant (nasal) allergies	Yes	No
Immunologic disorders	Yes	No

Patient name: _____ Date of birth: _____

The above information is accurate to the best of my knowledge

Patient signature: _____ Date: _____

I have reviewed the above information with the patient

Physician name (signature): _____ Date: _____

Physician name: _____

PHYSICAL EXAMINATION FORM

Constitutional	Well-developed	Y N	Obesity	Y N	Cachexia	Y N		
Vital signs	Temperature	Pulse	Resp	BP				
Head/Face/Neck	Mass or scar	Y N	Lymph nodes	Y N				
Eye	Anemia	Y N	Scleral injection	Y N	Corneal arcus	Y N		
ENT	Otorrhea	Y N	Nasal discharge	Y N				
Respiratory								
Inspection	Cough	Y N	Dyspnea	Y N	Asymmetry	Y N		
Percussion/	Hyperressonant	Y N	Dull to percussion	Y N				
Auscultation	Decreased breath sounds	Y N	Crackles	Y N	Rhonchi	Y N	Pleural rub	Y N
Cardiovascular								
Irregular pulse		Y N	Displaced apex beat	Y N				
Auscultation	Systolic murmur	Y N	Diastolic murmur	Y N	Continuous murmur			Y N
Carotid artery bruit		Y N						
Jugular vein distension		Y N						
Peripheral pulses								
Upper limb	Brachial	R L	Radial	R L				
Lower limb								
Femoral R L	Popliteal R L	Dorsalis Pedis R L		Posterior Tibial R L				
	ABI RIGHT	ABI LEFT						
Abdominal aorta	Palpable	Y N	Bruit	Y N				
Peripheral veins	Varicosities	R L	Leg edema	R L				
Lymphatic	Cervical nodes	Y N	Axillary nodes	Y N	Groin nodes	Y N		
Gastrointestinal								
Inspection	Distension	Y N	Caput medusae					
Palpation	Tenderness	Y N	Rebound	Y N	Guarding	Y N	Mass	Y N
	Hepatomegaly	Y N	Splenomegaly	Y N				
Ausculation/hernia	High pitched bowel sounds	Y N		Absent bowel		Y N	Bruit	Y N
Genitourinary	Testicular mass	Y N	Absent testis	Y N	Enlarged prostate			Y N
	Uterine mass	Y N	Distended bladder	Y N				
Skin	Lesion	Y N	Mass	Y N	Scar	Y N	Rash	Y N
Muskuloskeletal	Deformity	Y N	Immobility	Y N				
Neurological								
Cranial nerves	1st/2nd CN's	+ -		3/4/6 CN's		+ -	5th CN	+ -
	7th CN	+ -	8TH CN	+ -	9-12 CN	+		
Periperipheral NS	Motor	+ -	Sensory	+ -	Reflexes	+ -		

Assessment / Plan:

VASCULAR EXAMINATION FORM

Name: _____ Date: _____

Hospital: _____ Age: ____ yrs: Sex: ○ male ○ female Physician: _____

Resident: _____

Tel: _____ Profession: _____ Insurance: _____

Risk Factors

1. Diabetes: None 5

Adult onset, diet-controlled 5

Adult onset, insulin-controlled 5

Juvenile onset 5

2. Smoking: None for the last 10 years 5

None current, but smoked during the past 10 years 5

Current, less than one pack per day 5

Current, more than one pack per day 5

3. Hypertension: None 5

Controlled with one medication 5

Controlled with two medications 5

Requires more than two medications or uncontrolled by treatment 5

Diuretics 5, CE inhibitor 5, Beta blockers 5, Calcic antagonist 5,

ARA 2 antagonist 5, Other, specify _____

4. Hypercholesterolemia: None5

Controlled with one medication5

Uncontrolled 5

5. Positive family history of atherosclerotic disease: Yes ○ No ○

6. End-stage renal disease: Yes ○ No ○

Medical History

Allergy: _____ Trauma: _____

Infection/inflammation: _____ Arthritis: _____

Obesity: _____ Other diseases: _____

Pregnancy: _____ Hormones/ contraceptive pills: _____

Alcohol abuse: _____ Drugs:_____ Ergotamine: _____

Pulmonary Embolism: _____

Neurological Disease (peripheral/ stroke): _____

Hormonal Disorder: _____ Medication: _____

Renal Disease: _____ Medication: _____

Pulmonary Disease: _____ Medication: _____

Cardiac Disease

Coronary Disease: _____

Arrhythmia: _____ *Valvular Disease:* _____

Cardiac Failure: _____

Medication: _____

Surgial Procedures

1. _____
2. _____
3. _____
4. _____
5. _____

Clinical Presentation

Main symptoms-clinical _____

_____

_____

Symptoms-Signs	Duration	Comments
Disabling claudication		-mild, moderate, severe -muscle fatigue, aching or cramping
Rest pain		-at night or continuous -response to foot dependency or only to opiates -localized in the distal part of the foot or in the vicinity of ischemic ulcer or gangrenous toe
Numbness / Paresthesia		
Sensory decrease /loss		
Pallor		
Swelling		
Ulceration		-initial presentation or progress through rest pain -dorsum toes, plantar (toes or foot), heel, dorsum foot, multiple -regular/irregular margins -red, pale, cyanosed appearance
Gangrene		-initial presentation or progress through rest pain -toes or heel -infection, eschar formation ,shrinkage, mummification -spontaneous amputation
Blue toes		
Limb hair loss		
Rigor		

Rutherford classification **Fontaine classification**

Grade	Category	Clinical Presentation	Stage	Clinical
0	**0**	Asymptomatic	I	Asymptomatic
	1	Mild claudication		
I	**2**	Moderate claudication (> 200 מ' ראשון)	IIa	Mild claudication
	3	Severe claudication (< 200 מ' ראשון)	IIb	Moderate-severe claudication
II	**4**	Rest pain	III	Ischemic rest pain
III	**5**	Minor tissue loss		Ulceration or gangrene
	6	Major tissue loss	IV	

Skin : Cold _____ Warm _____ Smooth _____ Glossy _____ Thin _____ Blue _____

Red _____ Hair loss _____ Pruritus _____ Dermatitis _____ Other _____

Nails: Hypertrophied ____ Friable _____ **Mycosis:** _____ Skin _____ Nails _____

Muscular system: Muscular tone: _____ Muscular atrophy _____ Symmetry _____

Impotence: _____

Physical Examination

Height: _____cm Weight: _____ Kg Temperature: _____°C

Pulses: _____bpm, Blood pressure: _____ mmHg

Head+neck: _____

Chest - Lungs: _____

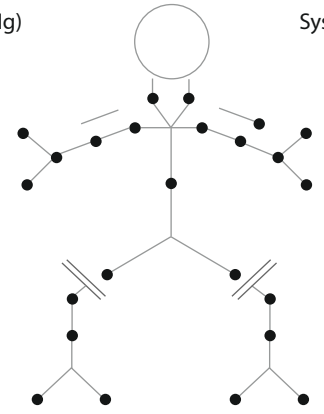
Heart: _____

_____

Abdomen: _____

Arterial System Examination

Systemic BP Rt (mmHg) ☐ Systemic BP Lt (mmHg) ☐



Ankle pressure (mmHg)	Ant tibia	Post tibial	Ant tibial	Post tibial
	☐	☐	☐	☐

Ankle-brachial Index (ABI) ☐ **Rt** ☐ **Lt**

Toe-brachial Index (ABI) ☐ **Rt** ☐ **Lt**

Pulse examination
(●——●)
A: Aneurysm
++: very good
+: palpable - diminished
± : palpable (doubtful)
- : no palpable

B: Bruit
T: Thrill

Continuous wave Doppler waveform
T: Triphasic
B: Biphasic
M: Monophasic
⌀: Absence of flow

Burger sign (+ or-) L R

Reactive hyperemia (+ or-) L R

Venous filling (+ or-) (normal 5-10 sec) L R

Allen test (+ or-) (check integrity of palmar arch) L R

Adson test (+ or-) (thoracic outlet syndrome) L R

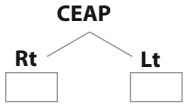
Exercise testing: Vel _____km/hr grade: _____% time _____ min distance: _____ m Sympt: _____
% decrease in ABI _____

Comments: _____

Venous System Examination

Venous insufficiency signs

	Right	Left
Heaviness		
Edema		
Pain		
Tenderness		
Lipoedema		
Skin pigmentation		
Healed ulcer		
Active ulcer		



CEAP classification

Class	Clinical presentation
0	No visible or palpable veins
I	Telangiectasis
II	Varicose veins
III	Edema
IV	Skin changes
V	Healed ulcer
VI	Active ulcer

Clinical examination of superficial leg venous system

V: varix, T: thrombosis, I: insufficiency (Dupplex)

	Right	Left
Greater saphenous (GSV)		
Lesser saphenous		
Anterolateral thigh		
Posteromedial thigh		
GSV anter. tibial branch		
Leonardo arch		
Calf perforator		
Thigh perforator		
Telangiectasis		