

EAST TENNESSEE VASCULAR CENTER, PLLC
SHAHIN ASSADNIA, M.D.
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 MORRISTOWN, TN 37814
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PATIENT HISTORY AND PHYSICAL

PATIENT NAME: _____ AGE: _____ DATE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN : _____

PLEASE LIST YOUR PREVIOUS SURGERIES

YEAR	SURGERY	YEAR	SURGERY

HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING MEDICAL CONDITIONS?

YES	NO		YES	NO	
		Lung Disease, asthma, emphysema			Stroke
		Liver Disease			Arthritis
		Diabetes			Blood Clots, DVT
		High Blood Pressure			Ulcers or Reflux
		Heart Disease			Thyroid Problems
		Cholesterol Problems			Other

ALLERGIES: _____

MEDICATIONS: _____

DO YOU CURRENTLY SUFFER FROM ANY OF THE FOLLOWING?

YES	NO		YES	NO	
		Excessive Bleeding			Chest Pain, Angina
		Skin Lesions, Ulcerations			Stomach Problems
		Shortness of Breath			Urinary Tract Problems
		Temporary Speech Problems			Temporary Paralysis of One Arm or Leg
		Temporary Blindness in One Eye			Back Problems
		Pain with Walking			Other Symptoms or Problems

FAMILY HISTORY: _____ STROKES _____ DIABETES _____ BLOOD CLOTS IN ARTERIES OR VEINS
 _____ HEART DISEASE _____ ABDOMINAL ANEURYSM

DO YOU USE TOBACCO PRODUCTS? () YES () NO

A. IF YES, HOW MUCH? _____ PACKS PER DAY B. IF YOU USED TO AND QUIT, WHEN? _____

IS THERE SOMEONE AT HOME, WHO WILL HELP YOU IF YOU BECOME ILL? _____ HUSBAND _____ WIFE
 _____ SON _____ DAUGHTER _____ OTHER