

Tami T. LaGraize, MD

GERIATRIC MEDICINE

CHRISTOPHER E. LaGRAIZE, MD

VASCULAR & ENDOVASCULAR SURGERY

155 Hospital Drive • Suite 410 • Lafayette, Louisiana 70503
(337) 289-9701 • Fax (337) 289-9702

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

NAME _____ AGE _____

FAMILY DOCTOR _____ DATE _____

PROBLEM: _____

DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES? Check **YES** or **NO**

DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	STROKE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART DISEASE ..	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LUNG DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HIGH BLOOD PRESSURE ..	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SEIZURES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	BLEEDING TENDENCIES ..	<input type="checkbox"/> YES	<input type="checkbox"/> NO
THYROID DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Type: _____		

PLEASE LIST PREVIOUS SURGERIES – WHEN? _____

CURRENT MEDICATIONS:	DOSAGE (MG)	HOW OFTEN PER DAY?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU TAKING ASPIRIN OR OTHER BLOOD THINNERS (Coumadin / Warfarin)? Y N

ALLERGIES: _____

HIGH CHOLESTEROL _____ HEIGHT _____ WEIGHT _____

SOCIAL HABITS:

USE OF TOBACCO: NEVER _____ CURRENT PACKS PER DAY _____ PREVIOUSLY , BUT QUIT _____ WHEN _____

USE OF ALCOHOL: NEVER _____ OCCASIONALLY _____ DAILY _____

FAMILY HISTORY: DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:

- DIABETES STROKE KIDNEY DISEASE HEART DISEASE
- LUNG DISEASE HIGH BLOOD PRESSURE BLEEDING TENDENCIES SEIZURE DISORDER
- CANCER Type/Who: _____

(OVER)

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL

- FEVER YES NO
FATIGUE YES NO
RECENT WEIGHT CHANGE YES NO
INSOMNIA YES NO
STRESS YES NO

EYES

- WEAR GLASSES / CONTACTS YES NO
EYE / VISION PROBLEMS YES NO

EARS, NOSE, MOUTH, THROAT

- EAR ACHES YES NO
HEARING LOSS / RINGING YES NO
NOSE BLEEDS YES NO
SINUS PROBLEMS YES NO
FREQUENT COLDS YES NO
DENTAL PROBLEMS YES NO
SORE THROAT / HOARSENESS YES NO

CARDIOVASCULAR

- CHEST PAIN YES NO
IRREGULAR/FAST HEARTBEAT YES NO
COLD EXTREMITIES YES NO
NUMBNESS/WEAKNESS - ARMS/LEGS YES NO
VARICOSE VEINS/PHLEBITIS YES NO
SWELLING OF FEET / ANKLES YES NO
PAIN WHEN WALKING YES NO

RESPIRATORY

- COUGHS YES NO
SHORTNESS OF BREATH YES NO
SPITTING UP BLOOD YES NO
ASTHMA / WHEEZING YES NO

GASTROINTESTINAL

- LOSS OF APPETITE YES NO
NAUSEA / VOMITING YES NO
DIARRHEA YES NO
CONSTIPATION YES NO
CHANGE IN BOWELS YES NO

HEMATOLOGICAL / LYMPHATIC

- SLOW TO HEAL AFTER CUTS YES NO
ANEMIA YES NO
BLOOD TRANSFUSIONS YES NO
BLEEDING / BRUISING YES NO
SWOLLEN GLANDS YES NO

ALLERGY / IMMUNOLOGIC

- ALLERGIES YES NO
HEPATITIS YES NO
HIV/AIDS YES NO

MUSCULOSKELETAL

- JOINT PAIN / SWELLING YES NO
MUSCLE JOINT WEAKNESS YES NO
BACK PAIN YES NO

NEUROLOGICAL

- FREQUENT HEADACHES YES NO
LIGHT HEADED / DIZZY YES NO
SEIZURES YES NO
PARALYSIS YES NO
CHANGE IN SPEECH YES NO

PSYCHIATRIC

- MEMORY LOSS / CONFUSION YES NO
NERVOUSNESS / DEPRESSION YES NO

ENDOCRINE

- HORMONE PROBLEM YES NO
EXCESSIVE THIRST OR URINATION YES NO
HEAT / COLD INTOLERANCE YES NO

INTEGUMENTARY / BREAST

- RASH / ITCHING YES NO
CHANGE IN SKIN / HAIR / NAILS YES NO
YELLOW JAUNDICE YES NO
BREAST PAIN YES NO
BREAST LUMP YES NO
NIPPLE DISCHARGE / BLEEDING YES NO

GENITOURINARY

- FREQUENT URINATION YES NO
PAINFUL / BURNING URINATION YES NO
BLADDER CONTROL PROBLEM YES NO
KIDNEY STONES YES NO
CHANGE IN FORCE OR STREAM YES NO
VENEREAL DISEASE YES NO

WOMEN (ONLY)

- LAST MENSTRUAL PERIOD _____
HOW MANY PREGNANCIES? _____
HOW MANY FULL TERM? _____
HOW MANY MISCARRIAGES? _____
AGE AT FIRST MENSTRUAL PERIOD _____
AGE AT FIRST PREGNANCY _____
DID YOU BREAST FEED? YES NO

MALES (ONLY)

- TESTICLE PAIN YES NO
PROSTATE PROBLEMS YES NO

SIGNATURE _____