AAA VASCULAR CARE – DR. TOUFIC SAFA
900 NORTHERN BLVD, STE 140
GREAT NECK, NY 11201

Patient Name:	Date of Birth:	Referring Doctor:
Reason for Today's visit:	Is your visit work related? ❑ Yes ❑ No	Is your visit related to a Motor Vehicle Accident? ❑ Yes ❑ No

Do you experience any of the following symptoms? (please check all that apply):

❑ Aching/Pain in legs	❑ Swollen Ankles	❑ Leg pain with exertion
❑ Heaviness	❑ Shortness of Breath	❑ Ulcerations/Sores on Legs
❑ Tiredness/Fatigue	❑ Leg Cramps	❑ Bleeding from Veins
❑ Itching/Burning	❑ Tingling/numbness	❑ Vision Loss
❑ Throbbing	❑ Restless Legs	❑ Weakness

Do you experience pain in your legs?	❑ one/ ❑ both	Does anyone in your family have any of the following?
Do you elevate your legs to relieve discomfort?	❑ yes/ ❑ no	❑ Circulation problems
Do you wear support hose prescribed by a doctor?	❑ yes/ ❑ no	❑ Varicose Veins
Do you do lot of standing during the day?	❑ yes/ ❑ no	❑ Diabetes
Have you ever had any tests done on your circulation?	❑ yes/ ❑ no	❑ Heart Disease
If yes, when and what type of test: _____		❑ High Blood Pressure
_____		Other Hereditary/genetic disease: _____

Medical History (please check all that apply):

❑ Heart Disease	❑ Diabetes	❑ Peripheral Vascular Disease
❑ Heart Attack	❑ High Blood Pressure	❑ Leg Ulcers
❑ Heart Valve Replacement	❑ Stroke	❑ Tendency to bleed
❑ Increased Cholesterol	❑ Kidney/Bladder Problems	❑ Other_____

Have you ever had any surgery? ❑ yes/ ❑ no	3.
If yes, please explain and include dates:	4.
1.	5.
2.	6.

Have you ever had a blood clot? ❑ yes/ ❑ no

Female patients: Have you ever been pregnant? ❑ yes/ ❑ no Are you currently Breast Feeding? ❑ yes/ ❑ no

Please list any allergies, if none write NONE: _____

Medications taken regularly that require a prescription:	4.
1.	5.
2.	6.
3.	7.

Over the counter medications, herbs, etc :