AorticAneurysm.org

Aortic Aneurysm Patient Resource Guide

We recommend printing this resource guide and providing a completed copy to your healthcare provider.

Remember to keep your health records private.

- The Aortic Aneurysm Patient Resource Guide is meant to be an informative tool for patients and healthcare providers.

- Answering these important medical questions allows you to take charge of your own health and learn more about your personal risk factors for developing an aortic aneurysm. The medical information you provide on this worksheet about your medical history and risks for developing an aortic aneurysm will be valuable for your healthcare providers.

- The Aortic Aneurysm Resource Guide is not intended for self-diagnosis and only your healthcare provider can determine your risk for developing an aortic aneurysm and recommend appropriate screening testing and treatments.

- The information you provide as part of this patient resource guide is private and should only be shared with your physician and healthcare team after giving them specific written permission. For more information, please refer to http://www.hhs.gov/ocr/privacy/

- For additional information please visit http://www.aorticaneurysm.org

- For questions contact: Dr. Grayson Wheatley
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  Phone: (267) 671-2667

INTRODUCTION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____/_____/_____ GENDER: (Circle one: MALE / FEMALE)

ADDRESS: _____

_____

TELEPHONE #1: ___(_____)_____-_____ (HOME)

TELEPHONE #2: ___(_____)_____-_____ (CELL)

TELEPHONE #3: ___(_____)_____-_____ (WORK)

YOUR PREFERRED CONTACT TELEPHONE is (Circle one: HOME / CELL / WORK)

E-MAIL: _____

Do you mind receiving periodic emails from your healthcare team? (Circle one: YES or NO)

WERE YOU REFERRED BY A PHYSICIAN? (Circle one: YES or NO)

REFERRING PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE NUMBER:

_____

_____

HOW DID YOU LEARN ABOUT OUR PRACTICE? _____

RISK FACTORS

HIGH BLOOD PRESSURE

HAVE YOU EVER BEEN DIAGNOSED WITH HIGH BLOOD PRESSURE? (YES / NO)

DO YOU CURRENTLY TAKE ANY BLOOD PRESSURE MEDICATIONS? (YES / NO)

PLEASE LIST THE BLOOD PRESSURE MEDICATIONS YOU ARE TAKING:

1. Name:_____ Dosage: _____ Frequency:_____
2. Name:_____ Dosage: _____ Frequency:_____
3. Name:_____ Dosage: _____ Frequency:_____
4. Name:_____ Dosage: _____ Frequency:_____
5. Name:_____ Dosage: _____ Frequency:_____

ELEVATED BLOOD CHOLESTEROL

HAVE YOU EVER BEEN DIAGNOSED WITH HIGH CHOLESTEROL? (YES / NO)

DO YOU CURRENTLY TAKE ANY CHOLESTEROL MEDICATIONS? (YES / NO)

PLEASE LIST THE CHOLESTEROL RELATED MEDICATIONS YOU ARE TAKING:

1. Name:_____ Dosage: _____ Frequency:_____
2. Name:_____ Dosage: _____ Frequency:_____
3. Name:_____ Dosage: _____ Frequency:_____

RISK FACTORS

DIABETES

HAVE YOU EVER BEEN DIAGNOSED WITH DIABETES? (YES / NO)

DO YOU MANAGE YOUR DIABETES WITH DIET? (YES / NO)

DO YOU CURRENTLY TAKE ANY MEDICATIONS FOR DIABETES? (YES / NO)

PLEASE LIST THE DIABETES-RELATED MEDICATIONS YOU ARE TAKING:

1. Name:_____ Dosage: _____ Frequency:_____
2. Name:_____ Dosage: _____ Frequency:_____
3. Name:_____ Dosage: _____ Frequency:_____
4. Name:_____ Dosage: _____ Frequency:_____
5. Name:_____ Dosage: _____ Frequency:_____

SMOKING

DO YOU CURRENTLY SMOKE? (YES / NO)

HOW MANY PACKS PER DAY? _____ HOW MANY YEARS? _____

HAVE YOU EVER SMOKED IN THE PAST? (YES / NO)

HOW MANY PACKS PER DAY? _____ HOW MANY YEARS? _____

WHAT YEAR DID YOU QUIT? _____

RISK FACTORS

HEIGHT AND WEIGHT

WHAT IS YOUR CURRENT HEIGHT? _____FT_____INCHES

WHAT IS YOUR CURRENT WEIGHT? _____ LBS

CONNECTIVE TISSUE DISORDER

HAVE YOU EVER BEEN DIAGNOSED WITH A CONNECTIVE TISSUE DISORDER?

(For example Marfan's Syndrome) (YES / NO)

WHAT YEAR WERE YOU DIAGNOSED? _____

WHAT IS YOUR DIAGNOSIS? _____

FAMILY HISTORY OF AORTIC ANEURYSMS

HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH AN AORTIC

ANEURYSM? (YES / NO)

WHICH RELATIVES? _____

_____

HAS ANYONE IN YOUR FAMILY EVER DIED FROM AN AORTIC ANEURYSM?

(YES / NO)

WHAT TYPE OF ANEURYSM? _____

RISK FACTORS

TRAUMA

HAVE YOU EVER BEEN INVOLVED IN A TRAUMATIC ACCIDENT? (YES / NO)

WHAT TYPE OF TRAUMA? _____

WHAT YEAR DID THE TRAUMA OCCUR? _____

WHAT INJURIES DID YOU EXPERIENCE?_____

_____

PREVIOUS AORTIC ANEURYSMS

HAVE YOU BEEN SCREENED FOR AN AORTIC ANEURYSM? (YES / NO) YEAR_____

HAVE YOU BEEN DIAGNOSED WITH AN AORTIC ANEURYSM? (YES/NO) YEAR_____

WHAT TYPE(S) OF AORTIC ANEURYSM(S) WERE YOU DIAGNOSED WITH?

_____

HAVE YOU HAD SURGERY FOR AN AORTIC ANEURYSM? (YES / NO)

LIST THE SURGERIES:

1. Procedure:_____ Year: _____
2. Procedure:_____ Year: _____
3. Procedure:_____ Year:_____