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: ______