PATIENT HISTORY

DATE_____________________ PATIENT'S NAME ____

DATE OF BIRTH____________________________ HOME PHONE____

FAMILY DR.______________________________________ REFERRING DR._______________________________________

REASON FOR VISIT____

EMAIL____HEIGHT_____________ WEIGHT_______________

HOW DID YOU HEAR ABOUT OUR OFFICE____

IS THIS VISIT ACCIDENT RELATED? YES OR NO IF YES, DATE OF ACCIDENT_________________ TYPE_________

SURGERIES: YES or NO (if yes, please complete table below)

SURGERY DATE	TYPE OF SURGERY

ILLNESSES: YES or NO (if yes, please complete table below)

DATE	ILLNESS	HOSPITAL STAY?

ALLERGIES AND MEDICATIONS

PLEASE LIST ANY ALLERGIES(*medication, food or environmental*) If none – please mark NONE:

- ❖ ____
- ❖ ____
- ❖ ____

DO YOU TAKE PRESCRIPTION MEDICATION? YES or NO

MEDICATION	DOSAGE	FREQUENCY

DO YOU TAKE OVER THE COUNTER OR HERBAL MEDICATIONS ON A REGULAR BASIS? YES or NO

MEDICATION	DOSAGE	FREQUENCY OF USE

DO YOU USE STREET DRUGS? YES or NO **if yes, please inform the doctor.*

PATIENT NAME: ____ DOB: _____________________

SOCIAL HISTORY (please circle all that apply/answer questions or give date as needed)

Do you exercise? Yes or No If so, what type of exercise do you do?________________________

Do you use alcohol? Yes or No If yes, how many drinks per day?____________________

How many years did you drink?____________ Quit Date?_____________________________

Do you smoke or use tobacco products? Yes or No If yes, how many packs per day?__________

How many years did you smoke or use tobacco?___________ Quit Date?_________________

Do you drink caffeinated beverages? Yes or No If yes, how many caffeinated drinks per day?______

PAST MEDICAL HISTORY (please check all that apply)

Anemia	Low Blood Pressure	Aneurysm(Where?)
Arthritis	Kidney Problems	Cancer (Type?)
Asthma	Blocked Blood Vessels	Shortness of Breath
Bleeding or Clotting Problems	Phlebitis/Cellulitis	Weakness of arm or leg
Diabetes	HIV/AIDS	Swelling of ankles or legs
GI Disorder/Stomach Problems	Seizures	Chest Pain
Eye Problems	Stroke/TIA	Ringing in Ears
Heart Attack	Thyroid Disease	Leg Pain
High Cholesterol	Back Pain	Exercise Regularly
High Blood Pressure	Hepatitis	Dizziness

FAMILY HISTORY

Put an X in the box for all that apply	MOTHER	FATHER	SISTERS	BROTHERS
Abdominal Aneurysm				
Bleeding Problems				
Blood Clots				
Cancer/what type?				
Diabetes				
Heart Disease				
High Blood Pressure				
Smoking History				
Stroke/TIA				
Vascular Disease				