THE VEIN CLINIC, INC. – NEW PATIENT HEALTH HISTORY

Name Date of Birth Today's Date

PRESENT ILLNESS

Describe your present medical symptoms: ______

List any drugs you are allergic to (what was the reaction?)

List your current medication (s) (Prescription and nonprescription drugs and birth control Pills)

Name: Dosage How many times/day?

PAST MEDICAL HISTORY

(1) Surgeries

Date Type of Surgery

(2) Previous significant medical problems/hospitalizations

Date Type of Illness

Do you have any of the following illnesses? (Circle yes or no)

Give any details of illness

Diabetes	yes	no	______
High Blood Pressure	yes	no	______
Lung Disease	yes	no	______
Heart Disease	yes	no	______
Cancer	yes	no	______
History of Stroke?	yes	no	______
Any Other Medical Problems?	yes	no	______

FAMILY HISTORY

Do you have relatives with any of the following illnesses? (Circle yes or no)

RELATIONSHIP/AND DETAILS

Heart Attack (age < 65)	yes	no	______
Any Cancer?	yes	no	______
Any Other Medical Problems	yes	no	______

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SOCIAL HISTORY

Marital Status: Occupation:

Do you smoke? How much? For how many years?

Do you drink alcohol? Drinks of wine/beer/hard liquor per day/week:

Any drug use? ☐ Yes, ☐ Marijuana ☐ Cocaine ☐ Intravenous Drugs ☐ Other

☐ No

REVIEW OF SYSTEMS

Do you have any unusual (Circle yes or no):

Fever?	yes	no	
Chills?	yes	no	
Fatigue?	yes	no	
Have you recently gained weight?	yes	no	how much?_______
Have you recently lost weight?	yes	no	how much?_______

RESPIRATORY

Persistent Cough?	yes	no
Shortness of breath?	yes	no

CARDIAC

Do you have any chest pain?	yes	no
Palpitations?	yes	no
Shortness of breath with minimal activity?	yes	no
Shortness of breath when lying flat?	yes	no
Swelling of legs?	yes	no
Do you have difficulty walking two blocks?	yes	no
Do you have difficulty climbing one flight of stairs easily?	yes	no

GASTROINTESTINAL

Any abdominal pain?	yes	no
Nausea?	yes	no
Vomiting?	yes	no

URINARY

Any burning with urination?	yes	no
Frequent urination?	yes	no

NEUROLOGIC

Any migraine headaches?	yes	no	with aura?______
Dizziness?	yes	no	
Blurry or Double vision?	yes	no	
Weakness in the legs?	yes	no	
Numbness in the legs?	yes	no	

MUSCULOSKELETAL

Any persistent joint ache?	yes	no
Any swelling in joints?	yes	no

HEMATOLOGIC

Any history of abnormal bleeding?	yes	no
Any history of excessive bruising?	yes	no

Do you have any symptoms not described above?