Health History

Name: _____ DOB: _____ Today's Date: _____

Primary Care Physician: _____

Reason for Today's Visit: _____

When did, this problem start? _____

Health History Please check all that apply.

Cardiovascular (Heart)

☐ Arrhythmia (Atrial Fibrillation) ☐ Thrombosis (Blood Clotting) ☐ Carotid Artery Disease

☐ Congestive Heart Failure (CHF) ☐ Coronary Artery Disease ☐ Deep Vein Thrombosis (DVT)

☐ Hypertension ☐ Myocardial Infraction ☐ Peripheral Vascular Disease ☐ Superficial Phlebitis

☐ High Cholesterol

Pulmonary (Lung)

☐ Asthma ☐ Chronic Bronchitis ☐ COPD ☐ Pneumonia ☐ Pulmonary Embolism ☐ Pulmonary

☐Hypertension ☐ Sarcoidosis ☐ Emphysema ☐ Sleep Apnea (CPAP Yes____ No____)

Gastrointestinal

☐ Cholestasis (Gallstones) ☐ Cirrhosis ☐ Colon Polyps ☐ GERD ☐ Hepatitis ☐ Irritable Bowel Disease

☐ Pancreatitis ☐ Diverticulitis

Renal/Genitourinary

☐ Acute Renal Failure ☐ Chronis Renal Failure ☐ Benign Prostatic Hypertrophy ☐ End Stage Renal Disease

☐ Endometriosis ☐ Erectile Dysfunction ☐ Glomerulonephritis

☐ Polycystic Kidney Disease ☐ Renal Stones ☐ Urinary Incontinence ☐ Urinary Tract Infections

Musculoskeletal/Connective

☐ Chronic Pain ☐ Fibromyalgia ☐ Fracture(s) ☐ Gout ☐ Osteoarthritis ☐ Osteoporosis ☐ Lupus

☐ Rheumatoid Arthritis

Endocrine

☐ Type 1 Diabetic ☐ Type 2 Diabetic ☐ Hyperthyroidism ☐ Hypothyroidism

Are you insulin dependent? _____ Are you on Metformin? _____

Neurological

☐ Alzheimer's Disease ☐ Dementia ☐ Cerebral Vascular Disease (Stroke) ☐ Headaches, Migraine

☐ Headaches, Tension ☐ Headaches, Sinus ☐ Parkinson's Disease ☐ Seizure Disorder ☐ TIA (mini-stroke)

Allergies

☐ Seasonal ☐ Eczema ☐ Chicken Pox ☐ Psoriasis ☐ Sinusitis, frequent

Drug/Food Allergies

☐ Shellfish ☐ Iodine ☐ Latex ☐ Contrast ☐ Benadryl

Other: _____

_____

Cancer

☐ Bone Cancer ☐ Brain Cancer ☐ Colon Cancer ☐ Hepatic Cancer ☐ Leukemia ☐ Lung Cancer

☐ Lymphoma ☐ Melanoma ☐ Pancreatic Cancer ☐ Renal Cancer ☐ Skin Cancer ☐ Testicular Cancer

☐ Thyroid Cancer ☐ Breast Cancer Other: _____

Other

☐ Cataract (Right Left or Bilateral) ☐ Glaucoma

Are you currently on Dialysis? Please Circle

Yes or No What days do you have dialysis? **M T W TH F S** How long have you been on dialysis? _____

Family History: Check if applicable and list family member's relationship to you.

☐ Aortic Aneurysm _____ ☐ High Blood Pressure _____ ☐ Stroke _____

☐ Cancer _____ ☐Brain Tumors _____ ☐ Migraine _____

☐ Epilepsy _____ ☐ Brain Hemorrhage _____ ☐ Asthma _____

☐ Allergies _____ ☐ Diabetes _____ ☐ Heart Disease _____

☐ Varicose Veins _____ ☐ Other _____

Social History

Have you ever smoked/chewed tobacco? ☐Yes ☐No If yes, how much per day? _____ When did you quit? _____

Have you ever taken any drugs not prescribed by a physician? ☐Yes ☐No What? _____

Do you consume alcohol? ☐Yes ☐No If yes, how much per week? _____

Do you use caffeine? ☐Yes ☐No How much per day? _____ What type? Coffee Tea Soda Chocolate

Do you exercise? ☐Yes ☐No How often? _____ What type of exercise? _____

Are you currently employed? ☐ Yes ☐ No Occupation: _____

Are you currently disabled? ☐ Yes ☐ No If yes, please explain: _____

***Surgical History*:** Please list all surgeries and the year they were preformed

Vein Surgery ☐Yes ☐No Please Explain: _____

All other surgeries:

_____

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Current Medications: Please list ALL medications you are currently taking, dosage and how often you take it. Please be sure to include over the counter AND prescribed medications.

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