PATIENT MEDICAL HISTORY

Today's Date: ____________________

Patient Name (last, first, middle initial): ____ Date of Birth: _________________

Preferred Pharmacy: ____ Phone Number: _________________

Allergies

☐ *None/No Known Allergies* ☐ *Adhesive Tape* ☐ *Anesthesia* ☐ *Asprin* ☐ *Codeine* ☐ *Latex*

☐ *Iodine/Shellfish/Contrast Dye* ☐ *Morphine* ☐ *Penicillin* ☐ *Sulfa Drugs* ☐ *Midazolam/Versed*

Reaction: ____

PERSONAL MEDICAL HISTORY: Have you ***ever*** had any of the following?

PROBLEM	✓
I Have No Medical Problems	
Asthma	
Environmental Allergies	
Cerebrovascular Accident (Stroke)	
Intermittent Stroke-Like Symptoms / TIAs	
Dizziness (Syncope)	
Migraine Headaches	
Seizure Disorders	
Bone Cancer	
Breast Cancer	
Colorectal (Colon) Cancer	
Lung Cancer	
Prostate Cancer	
Skin Cancer	
Other:	
Constipation:	
Crohn's Disease	
Diarrhea	
Heart Burn / Acid Reflux / GERD	
Hepatitis	
Liver Disease	
Bleeding Disorder (*What Type?*)	
Diabetes Type 1	
Diabetes Type 2	
Hyperlipidemia (High Cholesterol)	
Hyperthyroidism	
Kidney Disease	
Dialysis	
Obesity	
Thyroid Disease	
Cataracts	
Glaucoma	
Hard of Hearing / Hearing Loss	
Swallowing Problems	

PROBLEM	✓
Abdominal Aortic Aneurysm	
Aneurysm, Other Type	
Angina/Intermittent Chest Pain	
Arteriosclerotic Heart Disease (ASHD)	
Peripheral Antherosclerosis (PAD) Artery Blockages in the Legs or Arms	
Atrial Fibrilation / Intermittent Rapid Heart Beat	
Blood Clots or DVT in Legs	
Blood Clot in Lung (P.E.)	
Cardiac Arrhythmia	
Cardiomyopathy	
Congestive Heart Failure (CHF)	
Coronary Artery Disease (CAD) / Heart Disease	
Heart Attack	
High Blood Pressure /Hypertension	
Non-Healing Leg Ulcers / Sores	
Varicose Veins	
Spider Veins	
HIV / AIDS	
Tuberculosis	
Arthritis	
Chronic Low Back Pain	
Chronic Generalized Pain	
Gout	
Lupus	
Raynaud's Phenomenon	
Alcoholism	
Anxiety	
Dementia / Alzheimer's	
Depression	
Asthma	
Chronic Obstructive Pulmonary Disease (COPD) Emphysema	
Chronic Cough	
Sleep Apnea	
Tobacco Dependence	

Nevada
Vein and Vascular

PATIENT MEDICAL HISTORY

SURGICAL HISTORY

SURGERY	✓	NOTES
Abdominal Aortic Aneurysm Repair / Endograft		
Amputation (Body Part)		
Arterial Bypass Surgery Legs		
Arterial Stents – Legs		
Atherectomy – Legs		
AV Fistula		
Back Surgery		
Carotid Endarterectomy		
Cholecystectomy / Gallbladder		
Heart Bypass Surgery		
Heart Stenting Procedures		

SURGERY	✓	NOTES
Hysterectomy		
Hernia Repair		
Knee Replacement Surgery – Right or Left		
Tonsillectomy		
Surgery Related to Cancer		
Varicose Vein Surgery		
List All Other Surgeries:		

FAMILY HISTORY: Please indicate if any of your immediate relatives have any of the following by a ✓ **in the appropriate box.**

MEDICAL PROBLEM	MOTHER	FATHER	BROTHER	SISTERS
Alive				
Deceased				
Aneurysm				
Atherosclerosis of the Legs / Poor Circulation				
Carotid Artery Disease				
Heart Disease (ASHD) / Heart Attack				
Bleeding Disorder (*What Type?*)				
Blood Clots or DVT in Legs				
Cancer (*What Type?*)				
Chronic Obstructive Pulmonary Disease (COPD) (Emphysema)				
Cerebrovascular Accident (Stroke)				
Diabetes				
Kidney Disease				
High Blood Pressure / Hypertension				
Hyperlipidemia (High Cholesterol)				
Thyroid Disease				
Varicose Veins				
Unknown History				

PATIENT MEDICAL HISTORY

PATIENT NAME:_______________________________________

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Occupation: ___________________________ ☐ Retired ☐ Unemployed ☐ Disabled ☐ Home Maker ☐ Student

SMOKING HABITS

NON-SMOKER	CURRENT SMOKER	FORMER SMOKER	E-SMOKER
I Have Never Smoked ______	Packs Per Day ______	Stop Date ______________	Number of Cartridges Per Day _______
	Smoked Since (Year) ______ Or # of Years Smoked ______	Previously Smoked _________ of Packs Per Day	
		Smoked for _______ Years	

CHEWING TOBACCO HABITS

Oz. Per Week: _____ Quit Tobacco: _____ Previously Chewed _____ oz. per week Reason Stopped: _______________

DRINKING HABITS

☐ Heavy ☐ Social ☐ Moderate ☐ Non-Drinker ☐ Reformed Alcoholic

Liquor Patient Consumes #_______ of drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Beer Patient Consumes #_______ of drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Wine Patient Consumes #_______ of drinks per ☐ Day ☐ Week ☐ Month ☐ Year

LIVING WITH

☐ Alone ☐ Spouse ☐ Family Member ☐ Roommate ☐ Group Home ☐ Other: ______________

MEDICATIONS: List any medications you are currently taking – please include over the counter (Please Print)

MEDICATION	DOSAGE/FREQUENCY	PRESCRIBING DR.
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

PATIENT MEDICAL HISTORY

PATIENT NAME:____

REVIEW OF SYSTEMS: Please mark only those that apply within the ***LAST 30 DAYS***

PROBLEM	✓
GENERAL	
Dizziness	
Fever / Chills	
Fatigue	
Use of a Walking Device	
HEAD/EYE/EARS/NOSE/THROAT	
Blurred Vision Right / Left	
Temporary Loss of Vision Right / Left	
Severe Headaches	
Hearing Loss Right / Left	
Bloody Nose	
Difficulty Swallowing	
Drooping on One Side of Face Right / Left	
CARDIOVASCULAR	
Chest Pain / Pressure	
Palpitations / Skipped Beats	
Shortness of breath	
Pacemaker	
Coronary artery bypass or cardiac stents	
Swelling in Lower Extremities	
VASCULAR	
Leg cramping, muscle fatigue, aching when walking	
Buttock cramping, fatigue when walking	
Pain in feet / legs at rest	
Impotence	
Non-healing wounds	
Slow-healing wounds	
Skin discoloration on the legs or feet	
Varicose veins	
Spider veins	
PULMONARY	
Cough	
Sputum production	
CPAP / BiPAP use	
Use of home oxygen	
GASTROINTESTINAL	
Abdominal pain	
Black / tarry stools	
Red blood from rectum	
Nausea / vomiting	

PROBLEM	✓
GENITOURINARY	
Blood in urine	
Painful urination	
Frequent urination	
Urinary incontinence	
MUSCULOSKELETAL	
Joint pain or swelling	
Back pain	
Muscle weakness	
Muscle spasms	
INTEGUMENTARY	
Rash	
Wounds	
NEUROLOGICAL	
Numbness / tingling	
Weakness	
Dizziness	
Seizures	
Poor balance	
PSYCHOLOGICAL	
Depression	
Anxiety	
Dementia	
Addiction	
ENDOCRINE	
Weight gain	
Weight loss	
Heat / cold intolerance	
HEMATOLOGIC	
Abnormal bleeding / bruising	
Blood clot(s)	
Previous chemotherapy or radiation	
HIV	
ALLERGIC / IMMUNOLOGIC	
Asthma	
Frequent infections	
Hives	
Itchiness of eyes, nose, and / or mouth	

❑ **I HAVE REVIEWED ALL ABOVE SYMPTOMS AND I DO NOT CURRENTLY HAVE ANY OF THESE.**

Patient Signature: ____ Date: ____________________