PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ _____

Height: _____ Weight: _____ Occupation: _____

What brought you in today? _____

Do you personally have a history of:

Diabetes……..Y/N
High Blood Pressure…....Y/N
Heart Disease……..Y/N
Heart Attack……Y/N
Heart Valve Problems…….Y/N
Abnormal Heart Rhythm….Y/N
Pacemaker/Internal Defib…Y/N
Stroke……..Y/N

Poor Circulation to Legs……..Y/N
Emphysema/COPD/……Y/N
Sleep Apnea…….Y/N
Kidney Disease……Y/N
Asthma……..Y/N
HIV……...Y/N
Urinary Problems……..Y/N
Cancer……...Y/N

Rectal Bleeding……Y/N
Blood Clots/DVT…….Y/N
Anemia……Y/N
Seizures……Y/N
Jaundice……Y/N
Mental Illness……Y/N
Bleeding Problems……Y/N
Problems w/Anesthesia….Y/N

OTHER (PLEASE LIST ALL OTHER CONDITIONS/PROBLEMS):
_____

Do you currently have an infectious disease? Y/N If yes please explain: _____

Do you Smoke……Y/N If yes, when did you start?_____ How much do you smoke? _____
When did you quit? _____

Do you drink alcohol……..Y/N If yes, when did you start? _____ How much do you drink? _____
When did you quit? _____

Drug Use……Y/N Explain: _____

Do you have any allergies to medications? _____ If yes, please indicate drug and reaction: _____
_____

Please list all surgeries you have had including the approximate date: _____
_____
_____

What is your activity level: Low Moderate High

How far can you walk? _____

Has any blood relative ever had:

Diabetes……..Y/N
High blood pressure……Y/N
Heart Disease……..Y/N
Abdominal Aortic Aneurysm Y/N
Stroke……..Y/N
Poor Circulation/PAD……Y/N
Vein Disease……Y/N

Family History:

Fathers Age: _____ State of Health: _____ Age of Death (if applicable): _____

Mothers Age: _____ State of Health: _____ Age of Death (if applicable): _____

Siblings: _____

Please list any other information you would like us to know about you or your family history:
_____

Patient Signature: _____ Date: _____