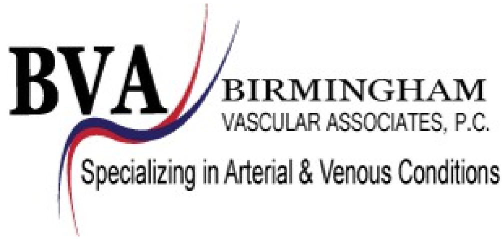

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PATIENT MEDICAL HISTORY FORM

Name:____**Date:**_________________________________

Social Security #:____**DOB:**______________________________________

Height:________________________**Weight:**______________________**Email:**________________________________

Primary Care Physician:_____________________________________**Referred by:**________________________________

Pharmacy Name/Location/Phone Number:____

Dialysis Center and Phone Number (if applicable):____

Do you have a: Pacemaker: Y_______ N_______Defibrillator: Y_______ N_______Cardiac Stents: Y_______ N_______

Name and Phone Number of Cardiologist: ____

Chief Complaint:____**When did occur?**_________________________

Drug Allergies:____

Do You Take Blood Thinners? (circle)

Coumadin________ Plavix________ Aspirin________ Xarelto________ Pradaxa________

What Medications are you currently taking?

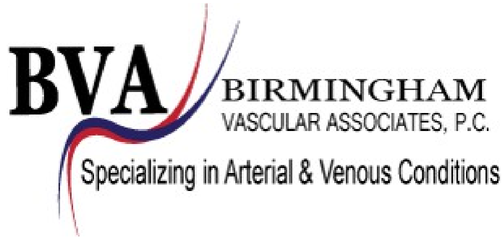
1. ____ **6.**____

2. ____ **7.**____

3. ____ **8.**____

4. ____ **9.**____

5. ____ **10.**____



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List all of your current medical conditions (ex: high blood pressure, asthma, diabetes, etc.):

1. ____ 4.____

2. ____ 5.____

3. ____ 6.____

Do you have hepatitis or any other chronic communicable disease?:

____

Do you have trouble with anesthesia? Y_______ N_______ (if yes explain)

____

List Prior Surgeries, you have had:

____Date:_____________

____ Date:_____________

____ Date:_____________

____ Date:_____________

(Female) Are you pregnant? Y_______ N_______ Date of last Menstrual Period:____________________

FAMILY HISTORY

List all medical illnesses affecting your immediate family: If deceased -at what age?

Mother:____

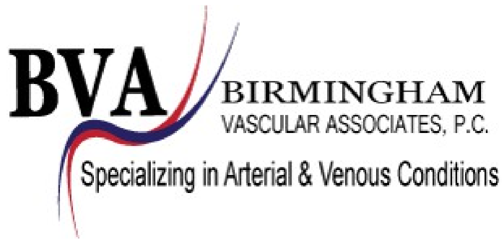
Father:____

Brother:____

Sister:____

SOCIAL HISTORY

Work status (circle) Full-time _______ Part-time_______ Disabled_______ Retired_______



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Current/previous occupation:____**How long?**________________________

Marital Status: (circle) **Single**_______ **Married**_______ **Separated**_______ **Divorced**_______ **Widowed**_______

Do you have children? **Yes**_______ **No**_______ **How Many?**_______

Do you smoke? **Yes**_______ **No**_______ **Former**_______

Do you consume alcohol? **Yes**_______ **No**_______ **How Much?**____

Do you exercise? **Yes**_______ **No**_______ **How often?**____

REVIEW OF SYSTEMS – (CIRCLE OR CHECK ALL THAT APPLY)

GENERAL: ***Check all that apply***

Fainting	Dizziness	Fainting	Fever	Decreased Appetite	Weakness
________________	________________	________________	_______________	________________	______________

HEAD, EYES, EARS, NOSE, THROAT (HEENT): ***Check all that apply***

Blurry Vision	Hearing Loss	Hoarseness	Ringing in Ears	Sore Throat	Total loss of Vision	Partial Vision Loss
______________	______________	___________	______________	___________	________________	________________

PULMONARY: ***Check all that apply***

Coughing up blood	Coughing up sputum	Cough	Short of Breath	Wheezing
________________	________________	________________	________________	________________

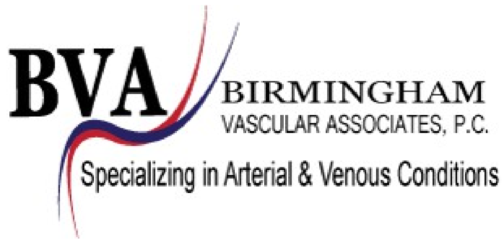
CARDIOVASCULAR: ***Check all that apply***

Ankle Swelling	Chest Pain	Irregular heart beat	Leg Pain with Exercise	Palpitations
________________	________________	________________	________________	________________

GENITOURINARY: ***Check all that apply***

Blood in Urine	Burning	Frequency	Hesitancy	Urgency	Incontinence
________________	________________	________________	________________	________________	________________

MUSCULOSKELATAL: ***Check all that apply***



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Joint Pain	Joint Swelling	Joint Stiffness	Low Back Pain	Muscle Aches	Neck Pain/Stiffness
______________	________________	________________	________________	________________	________________

GASTROINTESTINAL: ***Check all that apply***

Difficulty speaking	Heartburn	Nausea/Vomiting	Vomiting Blood
________________	________________	________________	________________

Abdominal Pain	Diarrhea	Constipation	Blood in Stool
________________	________________	________________	________________

SKIN: ***Check all that apply***

Rash	Sores	Pruritis (itching)
________________	________________	________________

NEUROLOGICAL: ***Check all that apply***

Headaches	Muscle weakness	Numbness
________________	________________	________________

PSYCHIATRIC: ***Check all that apply***

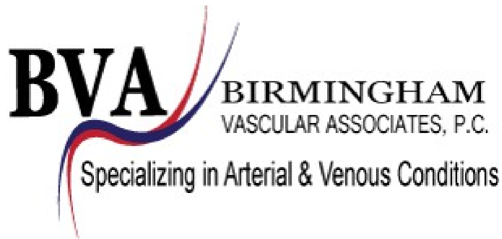
Feeling restless	Anxiety	Confusion	Depression	Sleep disturbance	Memory Loss
________________	________________	________________	________________	________________	________________

ENDOCRINE: ***Check all that apply***

Sensitive to temperatures	Excessive thirst
________________	________________

HEMATOLOGY/LYMPH: ***Check all that apply***

Easy bruising	Easy Bleeding	Swollen glands
________________	________________	________________



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VEIN HISTORY

Do you have a history of ulceration's, phlebitis, or deep vein thrombosis (DVT)? Y______ N______

How long have you had spider/varicose veins:?_____________________________________

Have you ever worn compression hose? Y______ N______ If yes, how long?___________________

Does prolonged sitting or standing aggravate your veins? Y______ N______

Does elevating your legs relieve your symptoms? Y______ N______

Do you have any of the following? (Circle or check all that apply)

Swelling/Edema	Pain	Fatigue/Tiredness	Ulceration	Burning/Itching
_______________	_______________	_______________	_______________	_______________
Throbbing	**Aching**	**Skin color changes**	**Varicose Veins**	**Spider Veins**
_______________	_______________	_______________	_______________	_______________