PATIENT HEALTH HISTORY FORM

Name: ________________________________ Date of Visit: ______________

Date of Birth: __________________________ Age: ______ Sex: (F) (M)

Please answer all the following questions, trying not to leave any blank.

Due to insurance industry's need to fully understand your medical needs it is necessary to complete as much of this form as necessary. This will also assist our office in assessing your particular needs for proper medical care.

Past Medical History

1) Have you ever been in the hospital as a patient? □ Yes □ No
if yes, specify when and for what reason:________________________________

____

____

2) Have you ever had surgery of any kind? □ Yes □ No
if yes, specify when and what type of surgery:_________________________

____

____

CURRENT MEDICAL HISTORY

3) Do you have?

	Yes	*No*	*Medications*		*Yes*	*No*	*Medications*
Heart Disease				Pacemaker			
Lung Disease				Anemia			
Hepatitis				Arthritis			
Leg Ulcer				Diabetes			
Asthma				Thyroid			
High Blood Pressure							

4) Are you presently under the care of a physician? □ Yes □ No If yes, please indicate who an for what illness or purpose:____________________

____

5) Please list all current medications (prescription & non-prescription)

Medication	Dosage	How often
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

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______________________ ______________________ ________________________
______________________ ______________________ ________________________

6)Do you take blood thinning medications?

□ Yes □ No if yes, list ______________________________________

7)Do you take birth control pills or hormones?

□ Yes □ No if yes, list _____________________________________

8)) Do you have any allergies? (i.e. medication, food, pollen) _________________________________

____

Describe how they affect you? (i.e. hives, rash, shortness of breath) ___________________________

____

Are you allergic to shrimp/shellfish/or any form of iodine, IVP dye? _____________________________

____

FAMILY HISTORY

It is important for us to know your family medical history. Please include if any family member has experienced varicose veins, spider veins, leg ulcers, congestive heart failure, and coronary artery disease or had bypass surgery.

Mother (Living) (deceased) Age: _____ Ailments: _______________________

Father (Living) (deceased) Age: _____ Ailments: _______________________

Brother(s) Age: _____ Ailments: _______________________

Sister(s) Age: _____ Ailments: _______________________

Children Age: _____ Ailments: _______________________

SOCIAL HISTORY

What is your profession?____

Do you smoke? If yes, how much? ____

Do you drink alcohol? If yes, how much? ______________________________________

WOMEN ONLY: Child Bearing History

1) Do you think you are presently pregnant? □ Yes □ No

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2) How many times have you been pregnant? □ Yes □ No

3) Do you intend to have any more children? □ Yes □ No

4) Are you currently breast-feeding? □ Yes □ No

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