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Patient Medical History Form

PLEASE NOTE: PROVIDERS AND STAFF ARE NOT RESPONSIBLE FOR MISINFORMATION OR INFORMATION THAT IS NOT DISCLOSED. PLEASE COMPLETE ALL SECTIONS OF THIS FORM.

Name: _____ DOB: ____/____/___

Primary Care Physician: _____ Referred By : _____

Reason for Visit: _____

Medical History					
Check **ONLY** those that apply					
☐	ADHD/ADD	☐	Ear Problems	☐	Osteoporosis
☐	Allergies	☐	Excessive Perspiration	☐	Parathyroid Disease
☐	Anemia/Blood Disorder	☐	Eye Problems	☐	Peripheral Disease
☐	Aneurysm	☐	Gastrointestinal Bleeding	☐	Pleurisy
☐	Anxiety Disorder	☐	Head Trauma/Injury	☐	Pneumonia
☐	Arthritis	☐	Headaches	☐	Pulmonary Embolism
☐	Atherosclerosis	☐	Heart Disease	☐	Radiation/Chemo
☐	Back/Neck Problems	☐	Heartburn/Reflux	☐	Rheumatic Fever
☐	Bladder or Kidney Problems	☐	Hepatitis/Liver Disease	☐	Skin Problems
☐	Blood Clots/DVT	☐	Concussion or Spinal Trauma	☐	Sleep Disorder
☐	Bowel Problems	☐	Dementia	☐	Stroke
☐	Bronchitis	☐	Herniated Disc	☐	Thyroid Disease
☐	CAD	☐	High Cholesterol	☐	Tuberculosis
☐	Cancer (Type:)	☐	HIV/AIDS	☐	Ulcers
☐	Cardiac Arrhythmia	☐	Hypertension	☐	Urinary/Bladder
☐	Carotid Blockage	☐	Kidney Disease	☐	Use of Blood Thinners
☐	Depression	☐	Lung Disorder/Disease	☐	Use of NSAIDS
☐	Diabetes	☐	Migraines	☐	Varicosities
☐	Dialysis	☐	Nephropathy	☐	Vascular Disease
☐	Dizziness	☐	Nerve Disease		

Are you **RIGHT** handed or **LEFT** handed? (please circle)

Latex Allergy?	Yes or No	Iodine Allergy?	Yes or No

Please list ALL MEDICATIONS that you are currently taking (including over-the-counter medications, vitamins, and herbal remedies):		
Name the Drug	Strength	Frequency Taken

Allergies to medications (please list)		
Name the Drug	Reaction to Medication	Onset Date

Preferred Pharmacy: _____

Where do you get your blood work done? _____

Surgical History or Hospitalizations (please list dates)		
Year	Reason	Hospital

List any recent (within the last year) x-rays, angiograms, ultrasounds, ultrasounds of neck (carotid), leg studies, pulmonary (lungs) etc.		
Year		

List any Cardiac Testing, Exercise Stress Test, Heart Catheterizations, Echocardiograms, etc.		
Year		

SOCIAL HISTORY			
Alcohol	How often did you have a drink containing alcohol in the past year?		
	☐ Occasional/Social ☐ Moderate ☐ Heavy		
Tobacco	Do you use tobacco? ☐ Yes ☐ No	Smoke Cigarettes ___ # packs/day:	
	Former Smoker ☐ Yes ☐ No	___ # of years	
	____ Year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
Drink:	Coffee	☐ Yes	☐ No
	Tea	☐ Yes	☐ No
	Soda	☐ Yes	☐ No
	DECAF/Caffeine _____	☐ Yes	☐ No
Marital Status	Married	☐ Yes	☐ No
Employment	Employed?	☐ Yes	☐ No
	Position:		
	Part/Full Time?		

FAMILY HISTORY		
Please check ALL that apply & list relationship		
☐	Heart Disease	
☐	Clot/DVT	
☐	Stroke	
☐	Vascular Problems	
☐	Pulmonary Embolism	

Circle the following that apply to you:

Do you have discomfort in your buttocks, thighs, calf, ankles, feet, right leg, left leg, both legs when walking? **Yes or No**

Do you have any sores or color changes on your feet? **Yes or No**

Do you have discomfort in your feet while you sleep? **Yes or No**

Have you ever had full or partial loss of vision in one or both eyes? **Yes or No**
Which eye? **Right Left Both**

Have you ever had weakness, tingling, numbness or clumsiness in your face, arms, or legs? **Yes or No**

Have you ever had difficulty speaking, been unable to speak, or had trouble finding words? **Yes or No**

Consent

I approve my Physician/Provider/Nurse/Staff to leave NORMAL test results on my answering machine or voicemail? **Yes or No**

If I am not available to receive my test results, I authorize you to release this information to:

_____

☐ I do NOT wish you to report any results to anyone other than myself (check the box)

Signature of patient/authorized person: _____ Date: ____/____/____