

Medical History Form

Name:

DOB:

Date:

Address:

Email:

Contact Number:

Primary reason for visit:

How long have you had the problem?

Any symptoms associated with the problem?

Major Medical History: (Please check any illnesses you have)

High blood pressure	Hypoglycemia	Neuropathy	HIV
Heart disease	G6PD Deficiency	Bruise/Bleed Easily	Bleeding disorder
Heart attack	Arthritis	Pancreatitis	Cancer inc. Skin
High Cholesterol	Fibromyalgia	Kidney disease	(type and treatment)
Asthma	Iron Deficiency	Kidney stones	
Emphysema/COPD	Hepatitis	Depression	
Stroke	Liver disease	History of Blood Clots	Other
Diabetes	Atrial Fibrillation	Deep Vein Thrombosis	Other
Thyroid disease	Heart valve disease	Immune Disorder	Other
Sleep apnea			

Previous Surgeries: (Please check any procedures you have had)

If yes, please detail:

Current Medications (Including: prescription/over the counter/vitamins/minerals/herbs)

Name	Dose	Name	Dose
Name	Dose	Name	Dose
Name	Dose	Name	Dose
Name	Dose	Name	Dose

Do you take any blood thinners?

Do you take Plavix?    Yes    No

Do you take Eliquis?    Yes    No

Do you take Aspirin?     Yes     No

Do you take any other blood thinner?    Yes    No

Do you take Coumadin?     Yes     No

Name:

Have you taken steroids in the last year?     Yes     No

Allergies to medications, foods and environmental causes:

Name:

Reaction:

Do you have any allergies to heparin?    Yes    No    Unsure

Family History: (Please check any illnesses that run in your family)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcer       | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Bleeding problems  |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Poor Circulation      | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Depression            | <input type="checkbox"/> Cancer (list type) |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Psychiatric Illnesses |   |
| <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/>                     | <input type="checkbox"/> Immune disorders      |   |
| <input type="checkbox"/> Other: _____        |  |  |   |

Social History:    Married    Single    Divorced    Widowed   Number of Children \_\_\_\_\_

Occupation \_\_\_\_\_

Smoking: Prior use?    Yes    No   Current use?    Yes    No   How many cigarettes per day \_\_\_\_\_

Alcohol consumption?    Yes    No   How many drinks per day \_\_\_\_\_

Caffeine consumption?    Yes    No   How many caffeinated beverages per day \_\_\_\_\_

Recreational drugs: Prior use?    Yes    No   Current use?    Yes    No

List any street drugs you formerly or currently use \_\_\_\_\_

Have you had any tests or studies relevant to today's visit? If yes, please note these below:

XRAY/CT/MRI  
Blood tests  
Biopsy results

Part of the body:

Who is your Primary Care Physician?

Full Name:

Address:

Phone:

In case of emergency  
contact:

Name:

Phone

*I have personally reviewed this history and review of systems.*

Signature

Date