Triangle Vein Clinic

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Patient Health History (page 1 of 2)

PATIENT NAME ______________________ ACCOUNT # ______________________

Please fill out this form completely.

PROBLEM LIST / PAST MEDICAL

Please check your diagnosed medical conditions, past and present:

☐ Arthritis	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Gout	☐ Heart Trouble	☐ Hemorrhoids	☐ Hepatitis
☐ High Blood Pressure	☐ Kidney Trouble	☐ Lumps and Bumps	☐ Migraines
☐ Paralysis	☐ Reflux	☐ Seizures	☐ Sleep Apnea
☐ Stroke	☐ Thyroid Trouble	☐ Tuberculosis	☐ Ulcers
☐ Varicose Veins	☐ Other	☐ Other	☐ Other

Have you ever had a blood transfusion? ☐ No ☐ Yes when: ______________________

ALLERGY

Drug allergies and reactions: ______________________

____

FAMILY

Please check the biologic **family member** diagnosed with any of the following medical problems and/or conditions:

☐ AIDS/HIV	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Arthritis	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Cancer, Breast	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Cancer, Family	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Heart Trouble	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Kidney Trouble	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Ulcers	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other
☐ Other	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Other

TVC Patient Health History (page 2 of 2)

SOCIAL

Have you ever smoked?

☐ Never

☐ Yes, but I quit ____ years ago, and smoked about ____ packs per day for ____ years

☐ Yes, I smoke ____ packs per day and have smoked for ____ years

Do you drink alcohol?

☐ No ☐ Yes Number of drinks per week ____

Do you or have you ever taken illicit drugs?

☐ No ☐ Yes Substance ______________________________

Marital status:

☐ Married ☐ Widowed ☐ Separated

☐ Single ☐ Divorced

Living status:

☐ Alone ☐ With ______________________________

Employment status:

☐ Full Time ☐ Retired ☐ Other

☐ Part Time ☐ Disabled ☐ Unemployed

Occupation: ____

MEDICATION

Please list all medications you are currently taking, including OTC medications and/or vitamin/herb supplements:

Medication name	Dosage	Frequency	Reason

PREGNANCY / BIRTH

List all pregnancies (specify delivery type, miscarriages): ____

____

PAST SURGICAL

List **all** past operations, including dates: ____

____

____

____

PATIENT SIGNATURE ____ DATE ______________

REVIEWED BY ____ DATE ______________

Updated Initials

___/ ___ /____ __________

___/ ___ /____ __________