

Patient Name: _____ MR#: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Family Doctor: _____ Referring Doctor: _____

Review of Systems (Please check the circle if you have any history of the problems listed below)

<p>General Symptoms</p> <input type="radio"/> Recent weight change <input type="radio"/> Fever or Chills <input type="radio"/> Night Sweats <input type="radio"/> Loss of Appetite <input type="radio"/> Headaches	<p>Musculoskeletal</p> <input type="radio"/> Joint Pain or Stiffness <input type="radio"/> Back Pain <input type="radio"/> Leg Pain with Walking <input type="radio"/> Gout <input type="radio"/> Hip or Knee Joint Replacement	<p>Hematology/Lymphatic</p> <input type="radio"/> Bleeding or Bruising Tendency <input type="radio"/> Anemia <input type="radio"/> Previous Blood Transfusion <input type="radio"/> AIDS or HIV Positive <input type="radio"/> Slow to Heal after Cuts <input type="radio"/> Phlebitis <input type="radio"/> Blood Clot/DVT
<p>Cardiovascular</p> <input type="radio"/> Heart Disease <input type="radio"/> Palpitations <input type="radio"/> Irregular Heart beat <input type="radio"/> Shortness of Breath <input type="radio"/> Heart Murmur <input type="radio"/> Heart Attack <input type="radio"/> Pacemaker <input type="radio"/> Congestive Heart Failure <input type="radio"/> Stroke <input type="radio"/> High Blood Pressure	<p>Respiratory</p> <input type="radio"/> Chronic Cough <input type="radio"/> Shortness of Breath <input type="radio"/> Emphysema <input type="radio"/> Asthma/Wheezing <input type="radio"/> Tuberculosis or TB	<p>Neurological</p> <input type="radio"/> Frequent Headaches <input type="radio"/> Convulsions/Seizures <input type="radio"/> Head Injury <input type="radio"/> Stroke <input type="radio"/> Paralysis <input type="radio"/> Memory Loss/Confusion
<p>Endocrine</p> <input type="radio"/> Diabetes <input type="radio"/> Thyroid Disease <input type="radio"/> Excessive Thirst/Urination <input type="radio"/> Hot or Cold Intolerance	<p>Ears, Nose, and Throat</p> <input type="radio"/> Hearing Loss <input type="radio"/> Hoarseness/Sore Throat <input type="radio"/> Lump in Neck <input type="radio"/> Nose Bleeds	<p>Psychiatric</p> <input type="radio"/> Nervousness or Anxiety <input type="radio"/> Depression <input type="radio"/> Insomnia <input type="radio"/> Alcohol/Drug Abuse
<p>Eyes</p> <input type="radio"/> Wear glasses or contacts <input type="radio"/> Blurred or Double Vision <input type="radio"/> Glaucoma <input type="radio"/> Cataracts	<p>Genitourinary</p> <input type="radio"/> Frequent Urination <input type="radio"/> Blood in Urine <input type="radio"/> Burning/Painful Urination <input type="radio"/> Kidney Stones	<p>Allergic/Immunologic</p> <p>Allergic to:</p> <input type="radio"/> Penicillin or other Antibiotic <input type="radio"/> Iodine or IVP dye <input type="radio"/> Local Anesthetics <input type="radio"/> Aspirin or other pain medications <input type="radio"/> General Anesthesia <input type="radio"/> Latex <input type="radio"/> Adhesive Tape
<p>Skin and Breast</p> <input type="radio"/> Easy Bruising <input type="radio"/> Varicose Veins <input type="radio"/> Breast Lumps/Discharge <input type="radio"/> Abnormal Mammogram	<p>Gastrointestinal</p> <input type="radio"/> Change in Bowel Movements <input type="radio"/> Frequent Diarrhea/Constipation <input type="radio"/> Rectal Bleeding/Blood in Stool <input type="radio"/> Abdominal Pain <input type="radio"/> Nausea/Vomiting <input type="radio"/> Frequent Heartburn <input type="radio"/> Hepatitis <input type="radio"/> Liver Disease <input type="radio"/> Stomach or Duodenal Ulcers	<p>Gynecological</p> <input type="radio"/> Irregular or Heavy Periods <input type="radio"/> Bleeding between Periods

Additional Notes

Social History

What is/was your occupation/profession? _____

Are you: Single Married Separated Divorced Widow

Do you smoke? Yes No

Are you a former smoker? Yes No If yes, when did you quit? _____

If yes, how many packs per day? _____

Do you drink alcohol? Yes No

If yes, how much in a week? _____



Medical History Worksheet

Patient Name: _____ MR#: _____ Date: _____

Past Surgeries	Medications (Over the counter and Prescription)	Allergies
1. _____	1. _____	<input type="checkbox"/> None 1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
Current Medical Problems		5. _____
1. _____	5. _____	
2. _____	6. _____	
3. _____	7. _____	
4. _____	8. _____	
	9. _____	

Family History

Do any of your family members have:

Varicose Veins Yes No Who? _____

Spider Veins Yes No Who? _____

Leg Ulcers Yes No Who? _____

Swollen Legs Yes No Who? _____

Have any of your family members had:

Vein Stripping Yes No Who? _____

Blood Clots/Pulmonary Embolism Yes No Who? _____

Blood Coagulation Disorder Yes No Who? _____

Females Only

Are you pregnant or trying to become pregnant? Yes No

Are you currently breast-feeding? Yes No

Are you taking hormones or birth control pills? Yes No

If yes, for how many years? _____

Were your veins made worse with pregnancy? Yes No

Total number of pregnancies you have had: _____ How many children? _____ # of miscarriages? _____

Additional Notes

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

For Office Use Only

Updated: _____ Reviewed by: _____ Pt Initials: _____

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