

THE VEIN CLINIC of SANTA BARBARA – NEW PATIENT HEALTH HISTORY

Name	Date of Birth	Today's Date
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PRESENT ILLNESS

Describe your present medical symptoms: _____

List any drugs you are allergic to (what was the reaction?) _____

List your current medication (s) (Prescription and nonprescription drugs and birth control Pills)

Name:	Dosage	How many times/day?
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PAST MEDICAL HISTORY

(1) Surgeries

<u>Date</u>	<u>Type of Surgery</u>	<u>Where Treated?</u>	<u>Surgeon</u>

(2) Previous significant medical problems/hospitalizations

<u>Date</u>	<u>Type of Illness</u>	<u>Where Treated?</u>

Do you have any of the following illnesses?			Give any details of illness
	Yes	No	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY

Do you have relatives with any of the following illnesses?			RELATIONSHIP/AND DETAILS
	Yes	No	
Heart Attack (age < 65)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

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SOCIAL HISTORY

Marital Status: _____ Occupation: _____

Do you smoke? _____ How much? _____ For how many years? _____

Do you drink alcohol? _____ Drinks of wine/beer/hard liquor per day/week: _____

Do you use marijuana? _____ Cocaine? _____ Intravenous drugs? _____

Do you exercise regularly? _____

Do you have any risks for HIV exposure? NONE blood transfusions bisexuality/homosexuality IV drug use multiple sex partners

REVIEW OF SYSTEMS

<p>Do you have any unusual:</p> <p>Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Night Sweats? <input type="checkbox"/> <input type="checkbox"/></p> <p>Chills? <input type="checkbox"/> <input type="checkbox"/></p> <p>Fatigue? <input type="checkbox"/> <input type="checkbox"/></p> <p>Have you recently gained weight? <input type="checkbox"/> <input type="checkbox"/> how much? _____</p> <p>Have you recently lost weight? <input type="checkbox"/> <input type="checkbox"/> how much? _____</p> <p>RESPIRATORY <u>Yes</u> <u>No</u></p> <p>Persistent Cough? <input type="checkbox"/> <input type="checkbox"/></p> <p>Sputum/Phlegm production? <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of breath? <input type="checkbox"/> <input type="checkbox"/></p> <p>CARDIAC <u>Yes</u> <u>No</u></p> <p>Do you have any chest pain? <input type="checkbox"/> <input type="checkbox"/></p> <p>Palpitations? <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of breath with minimal activity? <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of breath when lying flat? <input type="checkbox"/> <input type="checkbox"/></p> <p>Swelling of legs? <input type="checkbox"/> <input type="checkbox"/></p> <p>Can you walk two blocks without difficulty? <input type="checkbox"/> <input type="checkbox"/></p> <p>Can you climb one flight of stairs easily? <input type="checkbox"/> <input type="checkbox"/></p> <p>GASTROINTESTINAL <u>Yes</u> <u>No</u></p> <p>Any abdominal pain? <input type="checkbox"/> <input type="checkbox"/> Where? _____</p> <p>Nausea? <input type="checkbox"/> <input type="checkbox"/></p> <p>Vomiting? <input type="checkbox"/> <input type="checkbox"/></p> <p>Diarrhea? <input type="checkbox"/> <input type="checkbox"/></p> <p>Constipation? <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood in your stool? <input type="checkbox"/> <input type="checkbox"/></p> <p>Is this a change in your bowel habits? <input type="checkbox"/> <input type="checkbox"/></p> <p>URINARY <u>Yes</u> <u>No</u></p> <p>Any burning with urination? <input type="checkbox"/> <input type="checkbox"/></p> <p>Too frequent urination? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any blood in the urine? <input type="checkbox"/> <input type="checkbox"/></p> <p>Trouble starting urination? <input type="checkbox"/> <input type="checkbox"/></p> <p>Incontinence of urine? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any history of STDs? <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what kind of STD? <input type="checkbox"/> <input type="checkbox"/></p> <p>(gonorrhea, chlamydia, syphilis, genital warts, other _____)</p>	<p>NEUROLOGIC <u>Yes</u> <u>No</u></p> <p>Any unusual headaches? <input type="checkbox"/> <input type="checkbox"/></p> <p>Dizziness? <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of vision? <input type="checkbox"/> <input type="checkbox"/></p> <p>Blurry or Double vision? <input type="checkbox"/> <input type="checkbox"/></p> <p>Weakness in the arms? <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness in the arms? <input type="checkbox"/> <input type="checkbox"/></p> <p>Weakness in the legs? <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness in the legs? <input type="checkbox"/> <input type="checkbox"/></p> <p>MUSCULOSKELETAL</p> <p>Any persistent joint ache? <input type="checkbox"/> <input type="checkbox"/> Where? _____</p> <p>Any swelling in joints? <input type="checkbox"/> <input type="checkbox"/> Where? _____</p> <p>HEMATOLOGIC <u>Yes</u> <u>No</u></p> <p>Any history of abnormal bleeding? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any history of excessive bruising? <input type="checkbox"/> <input type="checkbox"/></p> <p>Any history of anemia? <input type="checkbox"/> <input type="checkbox"/></p> <p>GYNECOLOGICAL (WOMEN ONLY) <u>Yes</u> <u>No</u></p> <p>Total pregnancies you have had: _____</p> <p>Any miscarriages? <input type="checkbox"/> <input type="checkbox"/> When? _____</p> <p>Abortions? <input type="checkbox"/> <input type="checkbox"/> When? _____</p> <p>Date of your last menstrual period _____</p> <p>What type of birth control method do you use? _____</p> <p>When was your last mammogram? _____</p> <p>Do you have any symptoms not described above?</p> <p>_____</p> <p>_____</p>
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