



Medical History

Patient Name _____

Birth Date _____ Consult Date _____

Please check, circle, and / or fill in the blanks where appropriate.

IDENTIFYING INFORMATION

Age: _____ y.o. Gender: M or F Marital Status: S / M / D / W Occupation: _____

How did you hear about our office? _____ Referred by: _____

Family Doctor: _____ Phone: _____

Address: _____

PAST & CURRENT MEDICAL PROBLEMS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

PAST SURGICAL HISTORY

- Procedure: _____ Year _____
- Procedure: _____ Year _____
- Procedure: _____ Year _____
- Procedure: _____ Year _____

SOCIAL HISTORY

Smoke? _____ Pack(s)/Day _____ #of years _____

Alcohol intake? _____

History of substance abuse or addiction? Yes No

Specify: _____

of pregnancies: _____ # of deliveries: _____

FAMILY HISTORY

(Please specify: Mother, Father, Siblings)

- Y or N
- Varicose veins _____
- Spider veins _____
- Blood clots _____
- Bleeding disorder _____
- Diabetes _____
- Heart disease _____
- Lung disease _____
- Liver disease _____
- Cancer _____
- Other _____

MEDICATIONS

(Including: Birth Control, Vitamins, & Topical Medications)

1. _____ For _____
2. _____ For _____
3. _____ For _____
4. _____ For _____
5. _____ For _____
6. _____ For _____
7. _____ For _____
8. _____ For _____

ALLERGIES

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____

I have filled in the above questionnaire and answered the above questions honestly and accurately.

Patient or Parent/Legal Guardian Signature _____ Date _____

(if patient is less than 18 years of age, then Parent/Guardian signature is required)