

Date:	Name:	
	Date of Birth:	Age:

Please print clearly

MEDICAL HISTORY QUESTIONNAIRE

Review of Systems: Please indicate if any of the following medical conditions pertain to you:

System	NO	System	NO
Vascular: <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Impotence <input type="checkbox"/> Ulcerations/Sores on feet or legs <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Gangrene <input type="checkbox"/> Swelling <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Weakness <input type="checkbox"/> Blood Clots <input type="checkbox"/> Aneurysms <input type="checkbox"/> Heart Attack <input type="checkbox"/> Congenitive Heart Failure <input type="checkbox"/> Palpitations <input type="checkbox"/> Previous Vascular Disease	<input type="checkbox"/>	Respiratory: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/>
		Ear, Eyes, Nose Throat: <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Visual Changes <input type="checkbox"/> Vision Loss <input type="checkbox"/> Allergies	<input type="checkbox"/>
		Psychiatric: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<input type="checkbox"/>
		Allergic/Immunologic: <input type="checkbox"/> Drug Allergy <input type="checkbox"/> Environmental Allergy	<input type="checkbox"/>
Neurological: <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Speech Changes <input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	Bones/Joints/Muscles: <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Joint Pain	<input type="checkbox"/>
		Lymphatic/Hematologic: <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Problems	<input type="checkbox"/>
Gastrointestinal: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Reflux <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<input type="checkbox"/>	Endocrine: <input type="checkbox"/> Thyroid <input type="checkbox"/> Glands	<input type="checkbox"/>
		Genitourinary: <input type="checkbox"/> Kidney <input type="checkbox"/> Bladder <input type="checkbox"/> STD's	<input type="checkbox"/>
Integumentary (Skin): <input type="checkbox"/> Cancer <input type="checkbox"/> Skin Color Changes <input type="checkbox"/> Rash	<input type="checkbox"/>		

Family History

Please note any family history (Parents (P), Grandparents (G), Siblings (S), and/or Children (C), living or deceased) for the following medical conditions:

DISEASE/CONDITION	NO	YES	?	Relationship To You			
				P	G	S	C
<input type="checkbox"/> Strokes							
<input type="checkbox"/> High Cholesterol							
<input type="checkbox"/> Coronary Artery Disease							
<input type="checkbox"/> Peripheral Vascular Disease							
<input type="checkbox"/> Headaches							
<input type="checkbox"/> Joint Problems							
<input type="checkbox"/> Gastrointestinal Problems							
<input type="checkbox"/> Cancer							
<input type="checkbox"/> Arthritis							
<input type="checkbox"/> Diabetes							
<input type="checkbox"/> Heart Disease							
<input type="checkbox"/> High Blood Pressure							
<input type="checkbox"/> Kidney Disease							
<input type="checkbox"/> Thyroid Disease							
<input type="checkbox"/> Varicose Veins							
<input type="checkbox"/> Other							

Past History

Please list your medications:

_____	_____
_____	_____
_____	_____

Please list any allergies to medications:

Have you had any significant injuries in the past: YES NO

If yes, please explain:

Have you had any surgery? YES NO

If yes, please explain:

Social History

Do you use addictive agents? YES NO If yes, frequency: _____

Do you drink alcohol? YES NO If yes, frequency: _____

Do you use tobacco products? YES NO If yes, frequency: _____

Patient Signature: _____

Date: _____