HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care Doctor:	**Reason for visit:**
Referring Doctor:	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

CENTER FOR VEIN WELLNESS

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?	How many drinks per week?				
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	

WOMEN ONLY

Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No

OTHER PROBLEMS (*CHECK IF YOU HAVE, OR HAD ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE*)

General: ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness

Skin: ☐ Rash ☐ Itching ☐ Color changes

Respiratory: ☐ Cough ☐ Sputum ☐ Shortness of breath ☐ Wheezing

Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Swelling

Gastrointestinal: ☐ Heartburn ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea

Vascular: ☐ Calf pain with walking ☐ Leg cramping ☐ Leg Aches ☐ Leg Swelling ☐ Varicose Veins ☐ Redness/Inflammation

Musculoskeletal: ☐ Muscle or joint pain ☐ Swelling of joints

Neurologic: ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Numbness ☐ Tingling ☐ Tremor

Hematologic: ☐ Ease of bruising ☐ Ease of bleeding ☐ Blood clots

Endocrine: ☐ Heat or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst

Infectious Disease: ☐ HIV/AIDS ☐ Hepatitis B ☐ Hepatitis C

Signature: _____ **Date:** _____

Print Name: _____