THE VEIN & AESTHETIC CENTER

Patient General Medical History Questionnaire

Name _____ **DOB** _____

Age _____ **Sex M** _____ **F**_____

1. Medical History

Yes	No	High blood pressure			
Yes	No	Fainting or dizzy spells	Yes	No	Mitral valve prolapse
Yes	No	Open Heart Surgery	Yes	No	Frequent skin infections
Yes	No	Heart disease	Yes	No	Difficult skin healing or abnormal scars
Yes	No	Bleeding Disorder	Yes	No	HIV or AIDS
Yes	No	Hepatitis	Yes	No	Anxiety or Depression
Yes	No	Stroke	Yes	No	Asthma
Yes	No	Diabetes	Yes	No	Arthritis
Yes	No	Seizures	Yes	No	Autoimmune Disease
Yes	No	Migraine Headaches			

Other _____

_____

2. Surgical History (indicates surgeries, approximate year and any complications)

SURGERY	YEAR	COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Females: LMP_____ Contraception_____ Sexually Active __Y ___N
# of Deliveries____ Currently Pregnant __Y ___N Nursing? __Y ___N

4. Medications _____

_____

5. Drug Allergies/Sensitivities_____

6. Review of Symptoms

Yes	No	Muscle pain	Yes	No	Joint pain/swelling
Yes	No	Back or neck problems	Yes	No	Calf pain with walking
Yes	No	Shortness of breath	Yes	No	Lymph node enlargement
Yes	No	Chest pain	Yes	No	Bowel problems
			Yes	No	Easy Bruising

7. Personal Activities List

Yes	No	Do you smoke?	Number of cigarettes per day _____
Yes	No	Do you drink?	Number of drinks per day _____

8. Lifestyle

Exercise _____

Occupation _____

Patient Signature_____**Date**_____