

PATIENT HISTORY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Name: _____ Reason for today's visit: _____

Do you or any member of your family have any of the following:
Please select yes or no and indicate self or family member for any yes responses.

Diabetes	Yes	No	Self	Family Member
High Blood Pressure	Yes	No	Self	Family Member
Gout	Yes	No	Self	Family Member
Coronary Artery Disease	Yes	No	Self	Family Member
Kidney Problems	Yes	No	Self	Family Member
Liver Disease	Yes	No	Self	Family Member
Arthritis	Yes	No	Self	Family Member
Vascular Disease	Yes	No	Self	Family Member
Ulcers	Yes	No	Self	Family Member
Blood Disease	Yes	No	Self	Family Member
Nerve Disorder	Yes	No	Self	Family Member
Thyroid Disease	Yes	No	Self	Family Member
Other:	Yes	No	Self	Family Member
Please describe:				

Are you on any antiocoagulant medication? Yes No

Are you on any medication including vitamins or herbs? Yes No
 If yes, what are they?

Have you had any surgery? Yes No
 If yes, please explain:

Do you have any allergies to the following?

Latex	Yes	No	Tape	Yes	No
Aspirin	Yes	No	Steroids	Yes	No
Penicillin	Yes	No	Other:	Yes	No
Local Anesthesia	Yes	No	Please describe:		
Iodine (Shellfish)	Yes	No			
Codeine	Yes	No			
Sulfa	Yes	No			

Do you smoke? Yes No How much? cigarettes per day

Do you drink alcohol? Yes No How much? drinks per week

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