HEALTH SUMMARY

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Patient's Name (PLEASE PRINT): ______________________________

Today's Date: ______________ **DOB:** ______________ **SS#:** ______________________

REVIEW OF SYSTEMS: Are you CURRENTLY experiencing any of the following? Please check ALL boxes that apply.

CONSTITUTIONAL
- ☐ Good heath lately
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

GENITOURINARY
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of stream
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Sexual difficulty

CARDIO/VASCULAR
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins

ALLERGIES
- ☐ Runny/Stuffy nose
- ☐ Watery eyes
- ☐ Itchy nose, eyes and roof of mouth
- ☐ Sneezing
- ☐ Pressure in the nose and cheeks
- ☐ Ear fullness and popping
- ☐ Dark circles under the eyes
- ☐ Hives

SKIN
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails

NEUROLOGICAL
- ☐ Frequent or recurrent headaches
- ☐ Light headed or dizziness
- ☐ Convulsions/seizures
- ☐ Numbness or tingling
- ☐ Extremity Weakness

ENDOCRINE
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst/urination
- ☐ Heat or cold intolerance

EAR, NOSE & THROAT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat

SLEEP
- ☐ Snoring
- ☐ Stop breathing/ gasp for air at night
- ☐ Dry mouth/ Sore throat
- ☐ Wake up with headaches
- ☐ Often tired during the day/ while driving
- ☐ Often fall asleep while reading/ watching TV

EYES
- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Blurred or double vision

HEMATOLOGIC / LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Past blood transfusion
- ☐ Enlarged glands

RESPIRATORY
- ☐ Frequent coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma/Wheezing

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Blood in stool
- ☐ Stomach pain
- ☐ Hemorrhoids
- ☐ Nausea/Vomiting
- ☐ Heartburn

PSYCHIATRIC
- ☐ Memory loss
- ☐ Nervousness
- ☐ Depression

☐ **MUSCULOSKELETAL**
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain/cramps
- ☐ Back pain

CURRENT HEALTH HABITS:

How often do you exercise:	Smoking:	
☐ Never ☐ Rarely ☐ Daily	- Have you ever smoked? ☐ Yes ☐ No - Number of Years: _____	- How many packs currently smoked daily? _____ - Use of smokeless tobacco? ☐ Yes ☐ No

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DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. ______________________________ 3. ____________________________________ 5. ______________________________

2. ______________________________ 4. ____________________________________ 6. ______________________________

CURRENT MEDICATIONS: Please list ALL meds you are currently taking. Include dosage and how often you take each med.

MEDICATION (including over-the-counter)	DOSAGE	HOW OFTEN DO YOU TAKE?

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: ________
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: ________________
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: __________
- ☐ Kidney Stones
- ☐ Liver Disease, Type: _______
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: ________
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: ___________________

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VASCULAR HISTORY: Please check any methods you have used to relieve leg discomfort.

- ☐ Aspirin
- ☐ Cold packs
- ☐ Exercise/Walking
- ☐ Flexion/extension of your feet
- ☐ Ibuprofen
- ☐ Leg elevation
- ☐ Support hose
- ☐ Tylenol
- ☐ Warm soaks
- ☐ Wraps
- ☐ Other Method: ______________

Are you on your feet for long periods? ☐ Yes ☐ No **In what capacity**? ____________________

Walking/exercise: ☐ relieves your discomfort ***or*** ☐ makes it worse

Have you been treated for your veins before? ☐ Yes ☐ No

If yes, please check the following that apply:

- ☐ Injections
- ☐ Stripping
- ☐ Ambulatory Phlebectomy
- ☐ Radiofrequency Closure
- ☐ Laser Catheter Ablation
- ☐ Laser for Spider Veins
- ☐ Ultrasound-Guided Injections
- ☐ Other: ___________________
- ☐ By Whom? ________________________
- ☐ When? ________________________

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Females ONLY: Please write N/A on the lines that DO NOT apply to you, or leave blank.

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No **Are you currently breast feeding?** ☐ Yes ☐ No

Number of Pregnancies: ______ **Number of Miscarriages:** ______ **Number of Deliveries**: _______

Current form of Birth Control: ____

SURGERY HISTORY:

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy of:	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery ☐ R ☐ L	
Gallbladder	
Broken Bone Repair	

SURGERY	DATE
Joint Replacement	
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Hysterectomy	
Other: ______________________	

CURRENT SPECIALISTS:

SPECIALTY	NAME	LOCATION	PHONE #

FAMILY HISTORY: Check beside any disease that has affected your parents, brothers, and/or sisters.

☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Asthma
☐ Tuberculosis
☐ Liver Disease
☐ Kidney Disease

☐ Osteoporosis
☐ Stroke
☐ Epilepsy / Seizures
☐ Bleeding Problems
☐ Sickle Cell Anemia
☐ Diabetes / High Blood Sugar
☐ Thyroid Problems

☐ Cancer /Type:
☐ Alcohol Abuse
☐ Anxiety or Depression
☐ Glaucoma
☐ Other:

SOCIAL HISTORY:

- **Primary language if not English:** ________________________________
- **Current Employment:** ☐ Full-time ☐ Part-time ☐ Not working ☐ Retired ☐ Student
- **Religion:** describe any ethnic, religious or cultural beliefs you have that may/will influence your treatment.

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