SELF HISTORY

Name ______________________________ Date of Birth ______________

Reason for visit ______________________________ Date ______________

Pharmacy name ______________________________ Phone ______________

Preferred lab ______________________________ Phone ______________

Preferred imaging center ______________________________ Phone ______________

Height:	Weight:	Current pain level: 1 2 3 4 5 6 7 8 9 10

Allergies Check here if you have no known allergies ☐
Allergies to Medications: ______________________________

Medications Please list any medications you take, Check here if none ☐
**If you have a separate list, please attach. We can return your copy at the front desk.

Name of Medication	Dose	How often do you take it?

Family History Check if any of your immediate family members have had the following illnesses.

	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Aneurysm:	☐	☐	☐	☐	Heart Disease:	☐	☐	☐	☐
Anemia/Bleeding:	☐	☐	☐	☐	High Blood Pressure:	☐	☐	☐	☐
Stroke:	☐	☐	☐	☐	Kidney Disease:	☐	☐	☐	☐
Cardiac Disease:	☐	☐	☐	☐	Diverticular/Crohn's:	☐	☐	☐	☐
Carotid Disease:	☐	☐	☐	☐	Diabetes:	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	Malignant Hyperthermia:	☐	☐	☐	☐

Specify type of Cancer: ______________________________

Other Health issues that family members have had that we should know about: ______________________________

Social History

Tobacco Smoking Status: ☐ Never ☐ Former ☐ Everyday ☐ Somedays

Years of use: ___________ How many packs a day? __________ What year did you quit? ___________

Do you use chewing tobacco? Yes or No If yes, How often? _________________________

Deaf or Serious difficulty hearing? Yes or No Blind or serious difficulty seeing? Yes or No

I have difficulty with the following:

☐ Concentrating ☐ Walking ☐ Doing Errands Alone ☐ Remembering

☐ Climbing Stairs ☐ Making Decisions ☐ Dressing ☐ Bathing

Ambulatory Questions: ☐ Limited self-mobility ☐ Confined to chair

☐ Walks without restrictions ☐ Walks with assistive device(s) ☐ Independent in wheelchair

☐ Dependent in wheelchair ☐ Unable to walk ☐ Bed-ridden

Advanced Directive *This is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. There are two main types of advance directive - the "Living Will" and the "Durable Power of Attorney for Health Care."*

Do you have an Advanced Directive(s) in place? Yes or No

Alcohol Intake:	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
Caffeine Intake:	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
What is your current exercise level?	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
What is current stress level?	☐ None	☐ Occasional	☐ Moderate	☐ Heavy

Is a blood transfusion acceptable in the event of an emergency?	Yes ☐	No ☐
Do you currently live alone or with others?	Alone ☐	W/ others ☐

Surgical History Check here if none ☐

Date	Procedure	Hospital	Doctor

Have you ever had a balloon procedure or stents in your heart, kidneys, abdomen, legs or arms? (Y/N) IF yes, please list the type of procedure and date. ____

Medical History
Circle all that apply to you.

Anemia	Coronary Artery Disease	Vascular Disease	Asthma
Aneurysm	Diabetes Type 1 Diabetes Type 2	GERD	Renal Failure
A-Fib	High Blood Pressure	Varicose Veins	Peptic Ulcer
Back Problems	Heart Attack	High Cholesterol	Thyroid Disease
DVT (blood clot)	Kidney Disease	Stroke/ TIA	Emphysema/ COPD
Cancer	Specify Type of Cancer:		
Other:		Other:	

Are you currently on dialysis? Yes or No

If yes, what are your dialysis days? ____

Name and phone number of center: ____

Do you have any painful sores or ulcers? Yes or No   Do you go to Wound Care Center? Yes or No

If yes, where? ____

Have you recently been Hospitalized? Yes or No

If yes, where? ____

What was the reason you were in the Hospital? ____

____

When you walk to do you experience aching, cramping or pain in your legs? Yes or No

If yes, when do you feel pain?

☐ After walking 1 block ☐ Climbing a flight of stairs ☐ After walking 100 yards ☐ Walking at increased speed

Have you had any of the following Ultrasounds,Cat scans or MRIs recently? (check all that apply to you)

Carotids (neck)	Abdomen	Legs

If yes, where and when were they done?

____

My signature verifies that the information provided is correct to the best of my knowledge.
(If completed by someone other than the patient, please indicate your name and relationship to the patient.)

Patient ____

Signature ________________________________ Date ____________