THE VEIN INSTITUTE	PATIENT HEALTH HISTORY INFORMATION

Please Print

NAME:(MR. MRS. MS. DR.) _____ DOB:_____

PHARMACY NAME/ LOCATION:_____ PHONE:_____

DO YOU HAVE ALLERGIC REATION TO ANY MEDICATIONS?

MEDICATION: TYPE OF REACTION:

_____ _____

_____ _____

CHECK EITHER THE YES BOX OR NO BOX TO ALL APPLICABLE PRESENT OR PAST CONDITIONS:

YES	NO		YES	NO	
O	O	AIDS virus infection/ HIV	O	O	Heart Attack
O	O	Ancurysm	O	O	Heart Murmur
O	O	Asthma	O	O	High Blood Pressure
O	O	Prolonged Bleeding	O	O	Irregular Heart Beats
O	O	Chest Pains	O	O	Lupus/ Autoimmune Disease
O	O	Other Skin Cancers	O	O	Rheumatic Fever
O	O	Other Cancers (non- skin)	O	O	Diabetes
O	O	Seizures	O	O	Hepatitis
O	O	Emphysema	O	O	MRSA
O	O	Fever Blister/ Herpes	O	O	Other Conditions:_____
O	O	Are you currently pregnant? If yes, how many wks _____			
O	O	Have you experienced chest pain in the last month?			
O	O	Has anyone ever told you that you are a carrier of staph?			

PAST SURGERIES:

YES	NO		YES	NO	
O	O	ARTIFICIAL HEART VALVES	O	O	PROSTHESIS
O	O	Artificial Joints	O	O	Tranplant
O	O	Bypass	O	O	Vascular
O	O	Pacemaker			

LIST ANY PREVIOUS SURGERIES BELOW: DATE:

_____ _____

_____ _____

PLEASE LIST ALL MEDICATIONS, DRUGS AND VITAMINS YOU ARE TAKING AT THE PRESENT

TIME:MEDICATION & DOSAGE: (attach list if needed) HOW OFFTEN:

_____ _____

_____ _____