



# Health History

Date: \_\_\_\_\_

Welcome to our practice. To help us in evaluating you, please fill out the information below to the best of your ability.

Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex:  Male  Female

**What is the reason for today's visit?** \_\_\_\_\_  
 How long have you been aware of this? \_\_\_\_\_

**Major illnesses and hospitalizations:**

- Hypertension  Other: \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Coronary Artery Disease \_\_\_\_\_

**Previous surgeries:**

- Open heart (CABG)  Carotid endarterectomy (neck)  Other: \_\_\_\_\_  
 Gallbladder Which side? \_\_\_\_\_  
 Hysterectomy  Bypass on legs \_\_\_\_\_

**Medications:** (Prescription & Non-prescription) If you have a written list, we can make a copy. Otherwise, please list.

Medication	Dose (mg)	x per day	Medication	Dose (mg)	x per day

**Allergies:** (Please list drug, food, & environmental allergies with reaction.)  
 \_\_\_\_\_  
 \_\_\_\_\_

**Cholesterol:**

Has your cholesterol been checked?  Yes  No  
 Last checked: Date \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_

**Patient Social History:**

- Use of alcohol:  Never  Rarely  Moderate  Daily  
 Use of tobacco:  Never  Previously, but quit. (How long ago? \_\_\_\_\_)  Current (packs/day: \_\_\_\_\_)  
 Use of drugs:  Never  Yes (Type / frequency: \_\_\_\_\_)

Occupation: \_\_\_\_\_  
 Do you have a living will or advanced directive?  Yes  No

Weight: \_\_\_\_\_ (for medication dosing)  
 Height: \_\_\_\_\_

**Family History:** (Do you have family members with the following problems?)

Please list relationship.)

- Peripheral vascular disease \_\_\_\_\_  
 Coronary artery disease \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Varicose veins \_\_\_\_\_  
 Venous thrombosis \_\_\_\_\_

**Exercise routine:** \_\_\_\_\_

If you have pain or breathlessness with walking, please list walking distance prior to onset of symptoms. \_\_\_\_\_

- Symptoms:  leg pain  breathless  chest pain

For office use

Vital Signs  
**BP -**  
**P -**

statin  βB