

# BEVERLY HILLS VEIN CENTER HEALTH HISTORY

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Male Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please tell us your approximate Height \_\_\_\_\_ Weight \_\_\_\_\_

**Symptoms** Check (√) symptoms you have **currently** or **have had in the past year.**

- |  |  |   |  |
|--|--|---|--|
| <p><b>General</b></p> <input type="checkbox"/> Chills<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Headache            | <p><b>Urinary</b></p> <input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Lack of bladder control<br><input type="checkbox"/> Painful urination   | <p><b>Ear, Nose, Throat</b></p> <input type="checkbox"/> Bleeding gums<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Earache<br><input type="checkbox"/> Hoarseness<br><input type="checkbox"/> Persistent cough<br><input type="checkbox"/> Sinus problems | <p><b>Women only</b></p> <input type="checkbox"/> Abnormal Pap smear<br><input type="checkbox"/> Inter-period bleeding<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Extreme menstrual pain<br><input type="checkbox"/> Other<br>Date of last menstrual period _____ |
| <p><b>Skin</b></p> <input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Scars<br><input type="checkbox"/> Sores that don't heal | <p><b>Cardiovascular</b></p> <input type="checkbox"/> Chest pain<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Irregular heart beat<br><input type="checkbox"/> Swelling of ankles<br><input type="checkbox"/> Varicose veins<br><input type="checkbox"/> Low blood pressure | <p><b>Gastrointestinal</b></p> <input type="checkbox"/> Bowel changes<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Stomach pain   | Are you possibly pregnant? _____<br>Number of children _____<br>Are you currently Nursing? <b>Y N</b>  |

**ARE YOU ON DIALYSIS? Y N For how long? \_\_\_\_\_ Days you dialyze: M T W TH FR SAT**  
**DIALYSIS UNIT NAME: \_\_\_\_\_ Phone#: \_\_\_\_\_ DOCTOR NAME: \_\_\_\_\_ Phone#: \_\_\_\_\_**

**Conditions** Check (√) conditions you have **currently** or **have had in the past year.**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding Disorders<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hepatitis | <input type="checkbox"/> High cholesterol<br><input type="checkbox"/> HIV positive<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Migraine<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prostate problem<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid problem<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Vaginal infections<br><input type="checkbox"/> Other |
|--|---|--|---|

Do you drink alcohol? **Y N** How many drinks per day? \_\_\_\_\_

Do you have sleep apnea/snore? **Y N**

Do you smoke cigarettes? **Y N** How many per day? \_\_\_\_\_ How long? \_\_\_\_\_

**List Medications and Herbs-Include dosage and frequency**

NONE or  SEE SEPARATE LIST

**Allergies**

I have no allergies


Blood Thinners?  Heparin  Coumadin  Aspirin  Plavix

**Major Hospitalizations (Hospital and outcome)**

**SURGERY (Dates and outcome)**


I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Reviewed with modifications \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Reviewed No modifications \_\_\_\_\_ Date \_\_\_\_\_

Physician review and comments: \_\_\_\_\_  ROS and conditions reviewed