



**General Health History Form**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Why are you here today?**

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**How did you hear about NJ Vein Care?**

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**Are you on any medications either prescribed or over the counter?**  Yes  No

**Do you have any allergies to medication?**  Yes  No  
If yes, please list drug and reaction

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**Do you smoke tobacco?**  Yes  No **Packs per day for how many yrs?**

**Do you consume alcohol?**  Yes  No **Drinks per week?** \_\_\_\_\_

**Other drugs?** \_\_\_\_\_

**Have you had any past surgical procedures?**  Yes  No  
If yes, please list type and date

NJ Vein Care

Have you had any past hospitalizations?

Yes

No

If yes, please list reason and date

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Do you have any of the following conditions? (Please check all that apply and describe below)

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	Swelling of Legs	<input type="checkbox"/>	Leg Ulcers
<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Spider Veins	<input type="checkbox"/>	Other

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Family History. (Check all that apply)

	Father	Mother	Sibling	Other
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other medical information that you would like to share?

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_