MEDICAL HISTORY FORM

Please complete appropriately

FERRER & MONAGHAN VEIN AND AESTHETIC CENTER

Name: _____ Date of Birth:_____ Today's Date: _____

Current Problem: _____

Primary Care Physician: _____ Referring Physician: _____

Occupation: _____

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Medications (including dosages): ________

_____

_____

Allergies (including reaction): _____

_____

Date of last Flu Shot: _____ Date of last Pneumonia vaccine: _____

Date(s) of Covid vaccination: _____ Pfizer Moderna Johnson&Johnson

Most recent EKG: _____ with Dr.: _____

Personal Medical History: Have you ever had any of the following conditions (Check if yes)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer Type: _____
- ☐ COPD
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ GERD
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Myocardial infarction
- ☐ Peptic Ulcer disease
- ☐ Seizures
- ☐ Stroke
- ☐ Ulcerative Colitis
- ☐ Thyroid disease

Personal Surgical History: Have you ever had any of the following surgeries (Check if yes)

- ☐ Appendectomy
- ☐ Bariatric surgery
- ☐ Bladder surgery
- ☐ Cesarean section
- ☐ Gallbladder surgery
- ☐ Colon surgery
- ☐ Coronary artery bypass graft
- ☐ Esophagus surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Kidney surgery
- ☐ Neck surgery
- ☐ Prostate surgery
- ☐ Intestinal surgery
- ☐ Spine surgery
- ☐ Stomach surgery
- ☐ Thyroid surgery
- ☐ Breast surgery

List names and dates of surgeries: _____

_____

Family History: Indicate if any immediate family member has had any of the following conditions:

(Check if yes, and indicate relationship to you)

- ☐ Cancer_____
  Type: _____
- ☐ Anemia _____
- ☐ Diabetes _____
- ☐ Blood clots _____
- ☐ Heart disease_____
- ☐ Stroke _____
- ☐ High blood pressure _____
- ☐ Hepatitis _____
- ☐ Other _____

Female patients:

Are you pregnant? Y N Do you plan on becoming pregnant? Y N Breastfeeding Y N

How many deliveries? _____ Miscarriages? _____ Last menstrual period? _____

Social History:

Have you every smoked? Y N How much? _____ For how long? _____ When did you quit? _____

Alcohol use? Y N How much? _____

Review of Systems: Do you currently have any of the following symptoms or conditions (Check if yes)

General: ___ None

- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fainting spells

Eyes: ___ None

- ☐ Eye disease or injury
- ☐ Wear glasses or contacts
- ☐ Blurred or double vision

Ear, Nose, Mouth, Throat: ___ None

- ☐ Hearing loss
- ☐ Ear ache/infection
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Runny nose/cold
- ☐ Sore throat
- ☐ Sinus problems
- ☐ Enlarged neck glands/masses

Cardiovascular: ____ None

- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart valve problems
- ☐ Calf pain with walking
- ☐ Leg swelling

Respiration: ___ None

- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Short of breath with activity
- ☐ Short of breath lying flat
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ COPD
- ☐ Dependent on oxygen

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Musculoskeletal: ____ None

- ☐ Joint pain
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Leg pain with walking
- ☐ Leg pain at rest
- ☐ Broken bones _____
- ☐ Dependent on walker, cane, or wheelchair

Digestive: ____ None

- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark, tarry stools
- ☐ Abdominal pain

Urinary: ____ None

- ☐ Burning with urination
- ☐ Blood with urine
- ☐ Leakage of urine
- ☐ Kidney stones
- ☐ Prostate problems

Skin: ____ None

- ☐ Rash
- ☐ Skin infections
- ☐ Ulcers or sores
- ☐ Eczema, psoriasis, other _____

Neurologic: ____ None

- ☐ Frequent headaches
- ☐ Migraines
- ☐ Weakness
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Decreased sensation
- ☐ Difficulty with speech
- ☐ Dizziness

Psychiatric: ____ None

- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Phobias, fears _____
- ☐ Panic attacks

Endocrine: ____ None

- ☐ Heat or cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive sweating

Hematologic, Lymphatic: ____ None

- ☐ Easy bleeding/bruising
- ☐ Anemia
- ☐ Prolonged bleeding
- ☐ Blood clots
- ☐ Use of blood thinners
- ☐ Swollen lymph nodes
- ☐ Leg swelling

Allergic/Immunologic: ____ None

- ☐ HIV infection
- ☐ Hepatitis
- ☐ Immune deficiency
- ☐ Antibiotics needed for dental work