NORTHWEST
Vein & Aesthetic Center
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HEALTH HISTORY

NAME: **DATE:**

WHAT LOCAL PHARMACY DO YOU USE?

Do you have any acute or chronic health conditions (i.e. high blood pressure, diabetes, high cholesterol, autoimmune, thyroid, COPD)

Date:_____ **Type of Illness:**_____
Date:_____ **Type of Illness:**_____
Date:_____ **Type of Illness:**_____
Date:_____ **Type of Illness:**_____

Have you had any surgeries in the past? **YES** **NO**

Date:_____ **Type of Surgery:**_____
Date:_____ **Type of Surgery:**_____
Date:_____ **Type of Surgery:** _____
Date:_____ **Type of Surgery:** _____

Do you, or have you ever smoked? **YES** **NO** **Cigarettes/Cigars/Chew per day:** **Packs per week:**

When did you stop smoking?

Do you drink alcohol? **YES** **NO** **Drinks daily?** **Drinks weekly?**

Do you exercise: **REGULARLY** **OCCASIONALLY** **RARELY**

What do you do for exercise? **HEIGHT:** **WEIGHT:**

Would you classify your health as: **EXCELLENT** **GOOD** **FAIR**

FAMILY HISTORY	Cancer	Heart Disease	Diabetes	Varicose Veins	Bleeding Disorder	Clotting Disorder
Mother						
Father						
Brother						
Sister						
Mat. Grandm.						
Mat. Grandf.						
Pat. Grandm.						
Pat. Grandf.						

Notes:

Are you married? **YES** **NO**

Have you had children? **YES** **NO**

How many pregnancies?

Do you or have you ever had serious health problems with the following? (please circle)

Blood pressure	Eyes
Ears	Nose
Throat	Anemia
Heart	Stroke
Bleeding	Thyroid
Diabetes	Colon
Liver	Jaundice
Bladder	Kidneys
Pain When Walking	Blood clots
Headaches	Lungs
Weight Gain	Weight Loss

Physician Signature/Initial: