4700 Point Fosdick Dr. NW Suite 307 Gig Harbor, WA 98335
253-857-8346 (VEIN) www.nwveins.com

HEALTH HISTORY

NAME: DATE:

REASON FOR VISIT:

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 had, any serious or chronic health conditions? YES NO

Date:____________________ Type of illness:____

Date:____________________ Type of illness:____

Date:____________________ Type of illness:____

Date:____________________ Type of illness:____

Do you, or have you ever smoked? YES NO Cigarettes/Cigars 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	High Blood Pressure	Bleeding Disorder	Clotting Disorder
Mother						
Father						
Brother						
Sister						
Mat. Grandm.						
Mat. Grandf.						
Pat. Grandm.						
Pat. Grandf.						

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

LEAVE BLANK – DOCTOR WILL FILL OUT THIS PORTION

ABN	NORMAL	
		CONSTITUTIONAL
		EYES
		ENT
		NECK
		RESPIRATORY
		CARIDO
		ENDOCRINE
		GASTRO
		RENAL/URO
		MUSC/SKEL
		EXTREMITIES
		SKIN
		NEURO/PSYCH

Physician Signature/Initial: