New Patient Health History

Patient's Name:	Date:

Past Medical History			
		Year	Under MD Care
Varicose Veins	❑YES ❑NO		
Hemorrhoids	❑YES ❑NO		
Anemia	❑YES ❑NO		
Bleeding Disorders)	❑YES ❑NO		
Blood Clots	❑YES ❑NO		
Skin Cancer TYPE & Location	❑YES ❑NO		
Malignant tumor	❑YES ❑NO		
Diabetes	❑YES ❑NO		
Atopic dermatitis/ Eczema	❑YES ❑NO		
Psoriasis	❑YES ❑NO		
Arthritis	❑YES ❑NO		
Hepatitis	❑YES ❑NO		
Epilepsy	❑YES ❑NO		
Kidney Troubles	❑YES ❑NO		
Liver Troubles	❑YES ❑NO		
HIV /AIDS	❑YES ❑NO		
Respiratory Problems	❑YES ❑NO		
Stomach Ulcer	❑YES ❑NO		
Thyroid Problems	❑YES ❑NO		
High Cholesterol	❑YES ❑NO		
Hypertension	❑YES ❑NO		
Coronary Artery Disease	❑YES ❑NO		
Arrhythmias **Heart Murmurs**	❑YES ❑NO		
Pacemaker/Defibrilator **Artificial Hart Valves**	❑YES ❑NO		
Stroke	❑YES ❑NO		
Other - Please specify what other condition you have			

Past Surgeries, Hospitalizations, Injuries, Invasive Procedures		
Surgery/Hospitalization/Injury	**Date**	**Complication after procedure or anesthesia administration**

Family History (Father Mother, Sister Brother Grandparent)		
Disease	YES / NO	**Family Member**
Malignant tumor	❑YES ❑NO	
Skin Cancer	❑YES ❑NO	
Diabetes	❑YES ❑NO	
Deep vein thrombosis - DVT	❑YES ❑NO	
Varicose Veins	❑YES ❑NO	
Ulcers on Legs	❑YES ❑NO	
Other		

Do you smoke?	❑YES ❑NO
How many years?	
How many packs/ cigarettes per day?	

Thank you for completing this form. Please bring it with you to your doctor's appointment.

Patient Signature	Date:

Allergies and Current Medications

Patient's Name:	Date:

Allergies to medications-if none please type None (Allergie na leki-jesli nie ma zadnych napisz None)	
MEDICATION	**TYPE OF ALLERGIC REACTION**

Patient Current Medications-if none please type None	
Name of Medication	**DOSAGE and HOW OFTEN TAKEN**

I certify that above list of medications and allergies is up to date. There are no other medications I take besides ones listed above.

Patient Signature:	Date: