New Patient Health History

Patient's Name:	Date:

Past Medical History (Historia Zdrowia)			
	YES / NO	Year (Rok)	Under MD Care
Varicose Veins (Zylaki)	❑YES ❑NO		
Hemorrhoids (Hemoroidy)	❑YES ❑NO		
Anemia	❑YES ❑NO		
Bleeding Disorders (Problemy z Krwawieniem)	❑YES ❑NO		
Blood Clots (Zakrzepy)	❑YES ❑NO		
Skin Cancer (Rak Skory) TYPE & Location	❑YES ❑NO		
Malignant tumor (Tumor zlosliwy)	❑YES ❑NO		
Diabetes (Cukrzyca)	❑YES ❑NO		
Atopic dermatitis/ Eczema (Atopia skory/Egzema)	❑YES ❑NO		
Psoriasis (Luszczyca)	❑YES ❑NO		
Arthritis (Zapalenie stawow)	❑YES ❑NO		
Hepatitis (Zoltaczka Zakazna)	❑YES ❑NO		
Epilepsy (Padaczka)	❑YES ❑NO		
Kidney Troubles (Problemy z Nerkami)	❑YES ❑NO		
Liver Troubles (Problemy z Watroba)	❑YES ❑NO		
HIV /AIDS	❑YES ❑NO		
Respiratory Problems (Problemy z Plucami)	❑YES ❑NO		
Stomach Ulcer (Wrzody Zoladka)	❑YES ❑NO		
Thyroid Problems (Problemy z Tarczyca)	❑YES ❑NO		
High Cholesterol (Wysoki Cholesterol)	❑YES ❑NO		
Hypertension (Nadcisnienie)	❑YES ❑NO		
Coronary Artery Disease (Choroba wiencowa serca)	❑YES ❑NO		
Arrhythmias (Arytmia serca **Heart Murmurs** (Szmery w sercu)	❑YES ❑NO		
Pacemaker/Defibrilator (Rozrusznik serca) **Artificial Hart Valves** (Sztuczne zastawki)	❑YES ❑NO		
Stroke (Udar mozgu/Wylew)	❑YES ❑NO		

Other - Please specify what other condition you have
(opisz INNE choroby z ktorymi zostales zdiagnozowany)

Past Surgeries, Hospitalizations, Injuries, Invasive Procedures (Operacje /pobyty w szpitalu/ konuzje w przeszlosci)		
Surgery/Hospitalization/Injury (Operacje /pobyty w szpitalu/ kontuzje)	**Date** (data)	**Complication after procedure or anesthesia administration** (Komplikacje po zabiegu/ znieczuleniu)

Family History (Father Mother, Sister Brother Grandparent) (Historia rodzinna - tata mama, siostra, brat, babcia dziadek)		
Disease (Choroba)	YES / NO	**Family Member** (Czlonek Rodziny)
Malignant tumor (Tumor zlosliwy)	❑YES ❑NO	
Skin Cancer (Rak skory)	❑YES ❑NO	
Diabetes (Cukrzyca)	❑YES ❑NO	
Deep vein thrombosis - DVT (zakrzepy w zylach glebokich)	❑YES ❑NO	
Varicose Veins (Zylaki)	❑YES ❑NO	
Ulcers on Legs (Owrzodzenie nog)	❑YES ❑NO	
Other (Inne):		

Do you smoke? (czy palisz papierosy/ tyton) ?	YES NO
How many years? (Ile lat)?	
How many packs/ cigarettes per day? (Ile papierosow/paczek dziennie)?	

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 (Nazwa leku)	**TYPE OF ALLERGIC REACTION** (rodzaj reakcji alergicznej)

Patient Current Medications-if none please type None (Leki zazywane-jesli nie ma zadnych napisz "None")	
Name of Medication (Nazwa leku)	**DOSAGE and HOW OFTEN TAKEN** (Dawka i jak czesto brane)

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: