virginia beach diagnostics

MEDICAL HISTORY INFORMATION

v1.0

Name:_____ Age: _____ Today's Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Height: _____ft_____in Weight: _____ lbs

Reason for today's visit:_____

Medical History - Please check any illeness/conditions which **YOU** have had:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Vein Trouble
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Drug Abuse / Alcoholism
- ☐ Joint Replacement
- ☐ DVT
- ☐ Pulmonary Embolism
- ☐ Tuberculosis
- ☐ Nervous Disorder
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Gastrointestinal
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Heart Trouble
- ☐ Seasonal Allergies
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer: _____
- ☐ Stroke
- ☐ Diabetes
- ☐ Pneumonia
- ☐ HIV
- ☐ Hepatitis
- ☐ Asthma
- ☐ Other: _____

History of Serious Injuries/Illnesses: ☐ Yes ☐ No

If yes, please describe:_____

Surgical History and/or Surgical Complications: _____

_____

_____

Family Medical History - Please check any illness/conditions immediate **FAMILY** has had:

- ☐ High Blood Pressure _____
- ☐ Pulmonary Embolism _____
- ☐ Vein Trouble _____
- ☐ Kidney Disease _____
- ☐ DVT _____
- ☐ High Colesterol _____
- ☐ Heart Trouble _____
- ☐ Diabetes _____
- ☐ Lung Disease _____
- ☐ Blood Disorders _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Other:_____

Social History:

Tobacco Use: ☐ Yes ☐ In the Past ☐ Presently How Much? _____

Alcohol Use: ☐ Daily ☐ Ocassional ☐ None Other substance use or abuse? ☐ Yes ☐ No

Allergic to Latex: ☐ Yes ☐ No

Please list with Reactions: _____

_____

_____

Current Medications: _____

_____

_____