

Medical History 2

NYU VEIN CENTER ♦ 530 First Avenue, Suite 6D ♦ New York NY 10016

REVIEW of SYSTEMS

Patient Name (print): _____ Date: _____

Height _____ Weight _____

CONSTITUTIONAL SYMPTOMS

Good general health lately no yes
Recent weight change no yes
Fever/fatigue no yes
Headaches no yes

CARDIOVASCULAR

History of heart attack no yes
History of stroke no yes
Heart murmur (s) no yes
History of hypertension no yes
History of chest pain/CHF no yes
History of phlebitis/blood clots no yes
Do you have a pacemaker no yes
Shortness of breath w/ walking/lying flat no yes
Swelling of legs/ankles no yes

RESPIRATORY

Chronic or frequent coughs no yes
Spitting up blood no yes
Asthma or wheezing no yes
Chronic Lung Conditions no yes
Tuberculosis no yes

GASTROINTESTINAL

Loss of appetite no yes
Heartburn/abdominal pain no yes
Change in bowel movements no yes
Nausea or vomiting no yes
Frequent diarrhea no yes
Rectal bleeding/blood in stool no yes
Peptic ulcer (stomach or duodenal) no yes

MUSCULOSKELETAL

Joint pain no yes
Joint stiffness or swelling no yes
Weakness of muscles/joints no yes
Muscle pain or cramps no yes
Back pain no yes
Cold extremities no yes
Pain with walking no yes

INTEGUMENTARY

Rash or itching no yes
Change in skin color no yes
Change in hair or nails no yes
Varicose Veins no yes
Leg ulcers no yes

OTHER

History of Cancer no yes
Type of cancer: _____
Chemotherapy/Radiation no yes

Past Surgeries: _____

NEUROLOGICAL

Frequent or recurring headaches no yes
Light headed or dizzy no yes
Convulsions or seizures no yes
Numbness/tingling no yes
Tremors no yes
Paralysis no yes
Stroke no yes
Head injury no yes
Difficulty w/balance no yes

ENDOCRINE

Glandular/hormone problem no yes
Thyroid disease no yes
Diabetes no yes
Excessive thirst/urination no yes
Heat/cold intolerance no yes
Do you take Glucophage no yes
Skin becoming dryer no yes

Hematologic/Lymphatic

Slow to heal after cuts no yes
Bleeding or bruising tendency no yes
Anemia no yes
History of phlebitis no yes
Past transfusion no yes
Enlarged glands no yes
Blood borne disease no yes

GENITOURINARY

Renal disease/dialysis no yes
Difficulty w/ urination no yes
Frequent/burning urination no yes
Incontinence no yes
Blood in urine no yes
Menses/vaginal bleeding/pain no yes
Testicular/prostate problems no yes

Allergic/Immunologic

History of skin reaction/adverse reaction no yes
Penicillin or other antibiotics no yes
Iodine, methiolate or other antiseptic no yes
Do you take coumadin, aspirin
or other blood thinners no yes
Do you smoke? no yes
How much? _____
Do you drink? no yes
How much? _____

Allergies: _____

Current Medications:

Physician Signature _____