PHYSICIAN SIGNATURE _____

DATE _____

HEALTH HISTORY QUESTIONNAIRE

Please complete the following information

Patient Name _____**Age** _____**DOB**_____

Do you or a family member have an E-Mail address? _____

Referring Physician _____

What brings you to the doctor today? _____

How long have you had this problem? _____

Please check if any of the following apply to you:

_____ **High blood pressure**
_____ **Heart attack**
_____ **Hyperlipidemia**
_____ **Stroke**
_____ **Bleeding disorder**
_____ **Skin disorder**
_____ **Spots in front of eyes**
_____ **Memory loss**
_____ **Hearing difficulty**
_____ **Recent weight loss/weight gain**
_____ **Change in bowel habit**
_____ **Discoloration of feet or legs**
_____ **Leg swelling**
_____ **Blood clots**
_____ **Diabetes**
_____ **Heart problems**
_____ **Lung problems**
_____ **Kidney problems**
_____ **Headache**
_____ **Temporary blindness**
_____ **Dizziness**
_____ **Slurred speech**
_____ **Distended veins in neck**
_____ **Decline in appetite**
_____ **Sores or ulcer on feet or legs**
_____ **Pain, cramps while walking**
_____ **Varicose veins**
_____ **Other medical problems**

If yes to pain, cramps or tiredness in legs or thighs, please answer yes or no below:

_____ **Does it limit work/lifestyle?**
_____ **State distance you can walk in blocks before you get these symptoms.**
_____ **Does pain make you stop walking?**
_____ **Does pain go away if you rest for a few minutes?**

Operations (Please list)

Date	**Type**
_____	_____
_____	_____
_____	_____
_____	_____

Women Only
Are you taking oral contraceptives? _____ Pregnant? ____ Nursing?_____

Men Only
Do you have problems with impotence? (difficulty in obtaining or sustaining an erection) _____

All patients please complete the following.

Do you smoke cigarettes? _____ **If quit, when? _____**

Do you consume alcohol? _____ **Are you right or left handed? ____**

Please list all medications you are currently taking (please include dosage & frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy: _____ Phone:_____

Do you have allergies?_____ If yes, please list _____

_____

Occupation _____ If retired, what was your occupation?

_____

Family History

List health problems of your parents, brothers or sisters. Please include cause of death for any expired family member.

_____

_____

_____

_____

List all your physicians and their specialties: **Dialysis Center Information**

_____ _____

_____ _____

_____ _____