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Lithonia, GA 30058
(f) 404.350.1611

MEDICAL HISTORY FORM

DATE: _____

NAME: _____

REFERRING PHYSICIAN: _____

PRIMARY PHYSICIAN: _____

OTHER PHYSICIANS:_____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY (CHECK ALL THAT APPLY)

	PERSONAL	PARENTS	SIBLINGS	CHILDREN
DIABETES				
ARTHRITIS				
HEART DISEASE				
CANCER (type)				
HIGH BLOOD PRESSURE				
KIDNEY PROBLEMS/DIALYSIS				
HIGH CHOLESTEROL				
BLOOD CLOTS				
STROKE				
HEART ATTACK				
COPD				
CONGESTIVE HEART FAILURE				
GANGRENE				
PNEUMONIA				
SEIZURES				
HEPATITIS				
HIV/AIDS				
ANEMIA				
VARICOSE VEINS				
ULCERS/SORES ON LEGS				
PAIN IN LEGS WHILE WALKING				
LEG SWELLING				
ANEURYSMS				

SURGICAL HISTORY: (Type of Surgery / Date) _____

_____

SOCIAL HISTORY (CHECK ALL THAT APPLY)

- ☐ CURRENT SMOKER
  - CIGARETTES/DAY : ☐LESS THAN 1 ☐1 - 9 ☐ 10 - 19 ☐20 - 30 ☐40 OR MORE
- ☐ FORMER SMOKER: WHEN DID YOU QUIT? _____
- ☐ NEVER SMOKER
- ☐ SMOKELESS TOBACCO, E-CIGARETTES, OR CIGAR USE IN THE LAST 30 DAYS
- ☐ MARIJUANA USE
- ☐ ALCOHOL: ☐ SOCIALLY ☐ DAILY ☐ WEEKLY ☐ MONTHLY
- ☐ ILLICIT DRUG USE
- ☐ EMPLOYMENT STATUS: ☐ UNEMPLOYED ☐ FULL-TIME ☐ PART-TIME
- ☐ ALLERGIES (AND REACTION): _____
- ☐ NUMBER OF SIBLINGS_____CHILDREN_____

PRIOR VASCULAR STUDIES

HAVE YOU HAD ANY PRIOR VASCULAR STUDIES (Ultrasounds, MRI, CT scan)_____

IF SO, WHEN & WHERE?_____