# DELAWARE VALLEY VEINS/ASSOCIATED VEIN SOLUTIONS

Clear

## PATIENT MEDICAL HISTORY

Print

| **Patient Name** First MI Last | **Date of Birth** | **Today's Date** |
|---|---|---|
| | | |

| MEDICAL PROBLEMS Check all that apply | | |
|---|---|---|
| Mitral Valve Prolapse ☐ | Heart Trouble ☐ | Heart Murmur ☐ |
| High Blood Pressure ☐ | Angina ☐ | Stroke ☐ |
| Congenital Heart Disease ☐ | Hepatitis ☐ | Anemia ☐ |
| Diabetes ☐ | Epilepsy ☐ | HIV/AIDS ☐ |
| Fainting Spells ☐ | Kidney Trouble ☐ | Radiation Therapy ☐ |
| Blood Disorders ☐ | Ulcers or Lung Diseases ☐ | Joint Replacement ☐ |
| Stent ☐ | High Cholesterol ☐ | Thyroid Problems ☐ |
| Other | Other | Other |

| Smoking History (check one) | | |
|---|---|---|
| ◯ Current - How much? Pks/day | ◯ Former – How Long? Yrs | ◯ Never Smoked. |

| DRUG ALLERGIES OR UNUSUAL REACTIONS Check any you have had | | |
|---|---|---|
| Penicillin ☐ | Darvon ☐ | Sulfa Drugs ☐ |
| Codeine ☐ | Erythromycin ☐ | Valium (tranquilizers) ☐ |
| Novacaine (Xylocaine) ☐ | Sedatives & Barbiturates ☐ | Motrin ☐ |
| Demerol ☐ | Aspirin ☐ | Latex Allergy ☐ |
| Other | Other | Other |

| CURRENT MEDICATIONS | | |
|---|---|---|
| Are you currently taking any medication or drug – including over the counter meds? YES ◯ NO ◯<br>If YES, Please list all medications: | | |
| 1. | 2. | 3. |
| 4. | 5. | 6. |
| 7. | 8. | 9. |
| 10. | 11. | 12. |
| **Pharmacy Name** | Address | Phone |
| | City, State | Fax |

Clear

Email to: info@flanagansurgery.com

Submit