Milner Vein & Vascular

PATIENT MEDICAL HISTORY

NAME: ____ AGE: __________ DOB: _____________________

PRIMARY CARE PHYSICIAN: ____

REFERRING PHYSICIAN: ____

REASON FOR TODAY'S VISIT: ____

BP: _____________ HT: _____________ WT: _____________ PULSE: _____________________________

MEDICATION (NAME)	**DOSE (STRENGTH)**	**FREQUENCY (how often, 1 tab twice a day)**	**MEDICATION (NAME)**	**DOSE (STRENGTH)**	**FREQUENCY**

PREFERRED PHARMACY NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

**SOCIAL:

DO YOU USE TOBACCO? ______YES ______NO FORMER SMOKER? _________________________

DO YOU DRINK ALCOHOL? ______YES ______NO HOW OFTEN? _____________________________

On Dialysis? ______YES ______NO DAYS WMF or TTS

ALLERGIES: (MEDICATIONS, DYES, CONTRAST, LATEX, OTHER SUBSTANCE)

Medicine Name	**Type of Reaction**

PAST MEDICAL HISTORY: (blood clots, cancer, CAD, diabetes, high cholesterol, heart disease, hypertension, kidney disease, stroke, TIA, AFIB, liver disease, HIV)

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PAST SURGICAL HX (hospitalizations, arterial or vein procedures, bypass grafts, AAA repair, AVF/AVG (what side), BKA/AKA (what side)

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FAMILY HX (cancer, heart disease, hypertension, diabetes) (mother, father, grandparents, siblings)

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