Adult Health History

Name	Date of birth	Age	Date

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best answer. Thank you.

Chief complaint

Other concerns

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Symptoms *Circle all that apply*

Pain: R/L Fatigue: R/L Itching: R/L Cramping: R/L Heaviness: R/L Aching: R/L Pelvic pain: R/L Swelling: R/L
Burning: R/L Restless legs: R/L Ulcers: R/L Hyperpigmentation: R/L Throbbing: R/L Pelvic heaviness: R/L

What makes symptoms worse? How Long have you had symptoms:

What makes symptoms better?

Lifestyle changes because of leg discomforts

Times/duration per day legs are elevated

Compression Hose Help	HX of DVT	HX of Bursting Veins
☐ Yes ☐ No	☐ Yes Date: ☐ No	☐ Yes Date: ☐ No
Prescribing MD:	HX of Phlebitis	Use of Analgesics
	☐ Yes Date: ☐ No	☐ Yes ☐ No

Do you have diabetes? **Date of last A1C test?** **Result of last A1C test?**

☐ Yes ☐ No

Primary Care Doctor:

Medications *Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.*

Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day	Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day

Allergies *Do you have allergies or reactions to the following, please list*

Medications	Reaction	Foods	Reaction

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Big Sky Vascular

Medical History			Surgeries		
Major illnesses: (i.e., high blood pressure, high cholesterol, depression, etc.)	Year of diagnosis	Doctor treating	Surgeries	Year of surgery	Reason for surgery
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		

Family History

Mother ☐ Living ☐ Deceased	Ailments
Father ☐ Living ☐ Deceased	Ailments
# brothers alive: _____ # brothers deceased: _____	Ailments
# sisters alive: _____ # sisters deceased: _____	Ailments
# children alive: _____ # children deceased: _____	Ailments

Social History

Tobacco use

Cigarettes ☐ Never ☐ Quit date: _____ ☐ Current smoker: _____ packs/day; # of years _____

Other tobacco; ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week _____

Is alcohol use a concern for you or others? ☐ Yes ☐ No

Are you satisfied with your weight? ☐ Yes ☐ No	How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Socioeconomic

Occupation

Employer

Marital status

☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

Exercise

Do you exercise regularly? ☐ Yes ☐ No	If you do not exercise, why not?	
If yes, what kind of exercise:	How long (minutes)	How often?

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Adult Health History

Big Sky Vascular

Women Health History

# Pregnancies	# Deliveries	# Abortions	# Miscarriages

Review of Systems *Please check any current symptoms you have*

Constitutional

☐ Unexplained weight loss/gain

☐ Recent fever/sweats

☐ Unexplained fatigue/weakness

☐ Recent chills/cold sweats

Cardiology

☐ Chest pains/discomfort

☐ Palpitations

☐ Decreased exercise tolerance

Dermatology

☐ Rash

☐ New or change in mole

Endocrinology

☐ Cold/heat intolerance

☐ Increase thirst/appetite

ENT

☐ Change in hearing

☐ Congestion

☐ Sinus pain

☐ Sore throat

Hematology/Lymph

☐ Unexplained lumps

☐ Easy bruising/bleeding

Genitourinary

☐ Painful/bloody urination

☐ Leaking urine

☐ Night time urination

☐ Discharge: penis or vagina

☐ Concern with sexual functions

Gastroenterology

☐ Heartburn/reflux

☐ Bloody stools

☐ Change in bowel movement

☐ Nausea/vomiting/diarrhea

☐ Pain in abdomen

Musculoskeletal

☐ Muscle/joint pain

☐ Recent back pain

☐ Weakness

☐ Swollen joints

Neurology

☐ Memory loss

☐ Headaches

☐ Fainting

☐ Numbness/tingling in hands/feet

☐ Loss of balance

Ophthalmology

☐ Change in vision

☐ Eye pain

Psychology

☐ Anxiety/stress

☐ Sleep problems

Respiratory

☐ Cough/wheeze

☐ Coughing blood

☐ Short of breath with exertion

☐ Pain with breathing

Women

☐ No periods

☐ Heavy periods

☐ Painful periods

☐ Irregular periods

☐ Unusual vaginal bleeding

☐ Pelvic pain in the upright position

☐ Pain with intercourse

Date of last period: _____

Menopause age: _____

Do you have an Advanced Care Plan (Living Will)

☐ Yes ☐ No

Who is your surrogate decision maker?

Name: ☐ None

Patient signature	Date

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