



NORTHWEST

Vein & Aesthetic Center

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253-857-8346 (VEIN) www.nwveins.com

HEALTH HISTORY

NAME:

DATE:

REASON FOR VISIT:

Have you had any surgeries in the past? YES NO

Date: _____ Type of Surgery: _____
Date: _____ Type of Surgery: _____
Date: _____ Type of Surgery: _____
Date: _____ Type of Surgery: _____

Do you, or have you ever had, any serious or chronic health conditions? YES NO

Date: _____ Type of illness: _____
Date: _____ Type of illness: _____
Date: _____ Type of illness: _____
Date: _____ Type of illness: _____

Do you, or have you ever smoked? YES NO Cigarettes/Cigars per day: Packs per week:

When did you stop smoking?

Do you drink alcohol? YES NO Drinks daily? Drinks weekly?

Do you exercise: REGULARLY OCCASIONALLY RARELY

What do you do for exercise? HEIGHT: WEIGHT:

Would you classify your health as: EXCELLENT GOOD FAIR

FAMILY HISTORY	Cancer	Heart Disease	Diabetes	High Blood Pressure	Bleeding Disorder	Clotting Disorder
Mother						
Father						
Brother						
Sister						
Mat. Grandm.						
Mat. Grandf.						
Pat. Grandm.						
Pat. Grandf.						

Are you married? YES NO

Have you had children? YES NO

How many pregnancies?

Do you or have you ever had serious health problems with the following? (please circle)

- | | |
|-------------------|-------------|
| Blood pressure | Eyes |
| Ears | Nose |
| Throat | Anemia |
| Heart | Stroke |
| Bleeding | Thyroid |
| Diabetes | Colon |
| Liver | Jaundice |
| Bladder | Kidneys |
| Pain When Walking | Blood clots |
| Headaches | Lungs |
| Weight Gain | Weight Loss |

LEAVE BLANK - DOCTOR WILL FILL OUT THIS PORTION

ABN	NORMAL	
		CONSTITUTIONAL
		EYES
		ENT
		NECK
		RESPIRATORY
		CARIDO
		ENDOCRINE
		GASTRO
		RENAL/URO
		MUSC/SKEL
		EXTREMITIES
		SKIN
		NEURO/PSYCH

Physician Signature/Initial: