RCI VEIN & INTERVENTIONAL CLINIC
HEALTH HISTORY

NAME_____DATE_____ DATE of BIRTH_____

CONTACT INFORMATION:

PATIENT PHONE: Home: _____Work: _____ Cell: _____

EMERGENCY CONTACT: _____Phone: _____

TRANSPORTATION CONTACT: _____Phone: _____

CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

MAJOR MEDICAL ILLNESSES, HOSPITALIZATIONS, INJURIES:

_____ _____ _____

_____ _____ _____

Hospital Preference: St. Luke's Mercy

ALLERGIES:

Drugs: Name of drug reacted to: _____ Reaction: _____

_____ Reaction: _____

Xray Dye Allergy? ☐ NO ☐ YES Reaction: _____

Latex Sensitivity? ☐ NO ☐ YES Reaction: _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Your Occupation: _____

Do you smoke? ☐ NO ☐ YES If so, how much? _____ How long?_____

Have you ever smoked? ☐ NO ☐ YES If quit, how long ago? _____

Do you drink alcohol? ☐ Not ever ☐ Used to drink ☐ Occasionally ☐ Regularly

MEDICAL HISTORY – REVIEW OF SYSTEMS

Head & Neck	**No**	**Yes**
Headaches	☐	☐
Head injury	☐	☐
Fainting	☐	☐
Vision Loss	☐	☐
Wear glasses	☐	☐
Wear Dentures	☐	☐

Cardiovascular	**No**	**Yes**
Heart attack/failure	☐	☐
Hypertension	☐	☐
Irregular heart beat	☐	☐
Chest pain/tightness	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Swelling in feet/ankles	☐	☐
Stroke	☐	☐

Extremities		
Pain with walking	☐	☐
Varicose veins	☐	☐
Blood clots	☐	☐
Numbness/tingling	☐	☐

Respiratory		
Chronic cough/colds	☐	☐
Asthma/wheezing	☐	☐
Emphysema/COPD	☐	☐
Bronchitis/pneumonia	☐	☐