Heart Vein & Vascular LLC
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Integrative Cardiovascular Private Clinic

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Patients Name: _____

History Form

Date of Birth: _____

Medical Record #: _____

Primary Care Provider: _____

Drug Allergies/Sensitivities: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	**Date**

Family History of			Initial Risk Assessment		Social History
Y	N	Family Member		Date	☐ Married ☐ Single ☐ Civil Union
☐	☐	Alzheimer's Dz _____	☐ Alcohol/Drug Use	_____	☐ Divorced ☐ Widow(er)
☐	☐	Breast Ca _____	☐ STDs	_____	☐ Lives Alone ☐ Separated
☐	☐	CAD _____	☐ Domestic Violence	_____	Occupation: _____
☐	☐	Cerebrovas. Dz _____	☐ Depression	_____	Religious Preference: _____
☐	☐	Cervical Cancer _____	☐ Osteoporosis	_____	Advance Directive? ☐ Yes ☐ No
☐	☐	Colon CA _____	☐ Geriatric Assessment	_____	If Yes, Date: _____
☐	☐	Depression _____	☐ MMSE	_____	Educ.: ☐ JHS ☐ HS ☐ College
☐	☐	DM _____	☐ _____	_____	☐ Other _____
☐	☐	Fe Storage _____			
☐	☐	Glaucoma _____			
☐	☐	Hyperchol. _____			
☐	☐	HTN _____			
☐	☐	Ovarian CA _____			
☐	☐	Prostate CA _____			
☐	☐	Skin CA _____			
☐	☐	Thyroid Dz _____			

Signature: _____ Date: _____