FLORIDA LAKES
VEIN CENTER

Fecha _____

HISTORIA MÉDICA DEL PACIENTE

Nombre del Paciente: _____Fecha de nacimiento: _____

Problema: _____

Cuanto tiempo han estado presente los sintomas?_____

Historia Pasada-- por favor marque, si aplica.

GERD
COPD
Cardiac Disease
Obesity
Hypertension/ High blood pressure

Varicose Veins
Osteoarthritis / Arthritis Diabetes
DVT/ Blood Clot
Cancer: (type) _____

HIV
High Cholesterol
IBS
Hepatitis

Otro: _____

Past Surgical History: (please check mark if applicable)

Gallbladder
Breast
Hemorrhoids

Colon
Appendectomy
Total Abdominal Hysterectomy

Hernia (type): _____
Cancer (type): _____
Stents: _____

Otro: _____

Alimentos: _____

Historia Social-- por favor marque, si aplica.

Tobacco: **SI / NO** (packs per day)
Alcohol: **SI / NO** (drinks per day)

Married **Divorced** **Widowed** **Single**

RACE/ETHNICITY: HISPANIC

Family History: (please check mark, if applicable)

Hypertension
Pulmonary
Diabetes Mellitus
Cardiac
Varicose Veins
Cancer (type):_____

Please indicate on the medication sheet if you are taking any blood thinning medication!