Patient Name ______________________________________ Date ____________________________

MARK (X) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

GENERAL
- Depression
- Dizziness
- Fainting
- Headache
- Loss of weight
- Nervousness
- Numbness

EYE/EAR/NOSE/THROAT
- Visual disturbances
- Vision Flashes
- Vision Halos
- Earache
- Loss of hearing
- Nosebleeds
- Hoarseness
- Difficulty swallowing

CARDIOVASCULAR
- Blood Clots
- Chest pain
- Irregular heart beat
- High blood pressure
- Low blood pressure
- Murmur
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins

MUSCLE/BONE/JOINT/SKIN

Pain, weakness, numbness in:
- Arms
- Legs
- Back
- Hips
- Hands
- Feet
- Neck
- Shoulders
- Bruise easily
- Sore that will not heal

MEN
- Erection Difficulties

Are you currently taking a blood thinner? ____________ Are you currently taking Aspirin? ____________

Pharmacy Name: __________________________Pharmacy Number: ______________________________

FAMILY HISTORY

Family History (Please Mark)	Mother	Father	Brother (s)	Sister (s)
Alive				
Deceased				

Diseases and conditions (Please mark)	Mother	Father	Sister(s)	Brother(s
Aortic Aneurysm				
Blood clots				
Cancer				
Diabetes				
Chemical dependency				
Heart diseases/stroke				
High blood pressure				
Kidney disease				
Peripheral vascular disease				
Varicose veins				

Pregnancies

How many Live births:

How Many Pregnancies: