TAYLOR VEIN SOLUTIONS

Ganesh Ramaswami MD,PhD
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Phone: 734-287-1950 Fax: 734-287-1954

Patient History Form

Patient Name: _____ Date of Birth: _____

Medication List:

Medication Name	Strength/ Dose (mg)	Number of pills /dose	Number of times /day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Past Medical History

	Yes	No
Diabetes		
High Blood Pressure		
Stroke		
Heart Disease/ Heart Attack		
Kidney Stones		
Thyroid Disease		
Seizures		
Bleeding Disorder		

	Yes	No
Emphysema/ COPD		
Pneumonia		
Depression/ Bipolar		
Mental Illness		
Dementia (Alzeimer's etc)		
Ulcers		
Liver Disease		
High Cholestrol		

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Sexually Transmitted Disease		
Tuberculosis		
Rheumatic Fever		
Asthma		
Anxiety		

Irritable Bowel Syndrome		
Glaucoma		
Osteoporosis		
Cancer		
□ Cancer Type		

List all Allergies:_____

_____

Surgical History /Hospitalizations

Any Hospitalizations and Surgeries	Year

Family History

	Living	Age	Deceased	Age at death	Medical History (Ex: Diabetes Stroke, Heart Attack)
Father					
Mother					

Siblings	_____Sister/s	_____Brother/s	□**Healthy**	
Children	_____Sons	_____Daugters	□**Healthy**	

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Patient Name: _____ Date of Birth: _____

Patient Social History

Use of Alcohol	□ **Never** □ **Rarely** □ **Moderate** □ **Daily**
	Monthly or less/ 2 to 4 times a month /2 to 3 times a week
	How many drinks did you have on a typical day when you were drinking in the past year? _____
	How often did you have 6 or more drinks on one occasion in the past year?
Use of Drugs	□ **Never** □ **Yes, Type /Frequency_____**
Use of Tobacco	□ **Never** □ **Previously,but quit When? ___ ___Current Packs/Day**
	If 'current smoker': How soon after you wake up do you smoke your first cigarette? _____ If 'current smoker' : Are you interested in quitting? _____
Exercise	□ **No** □ **Yes Type /Frequency_____**
Caffeine	□ **No** □ **Yes Type /Frequency_____**