Accredited Vascular Laboratory — ICAVL

HISTORY *(Please fill out form as completely as possible.)*

G68(1)-0804

DATE _____ CHART # _____

NAME _____ DOB _____ AGE _____

REFERRING PHYSICIAN _____ FAMILY DOCTOR _____

REASON FOR VISIT _____

_____

DATE PROBLEMS STARTED _____

HISTORY OF PRESENT ILLNESS *(To Be Completed By Medical Staff)*

SOCIAL HISTORY *(Patient Please Check Answer)*

DO YOU OR HAVE YOU EVER *USED* **ALCOHOL**? ☐ YES ☐ NO If YES, indicate quantity and how long. _____

DO YOU OR HAVE YOU EVER *USED* **TOBACCO**? ☐ YES ☐ NO If YES, indicate quantity and how long. _____

ALLERGIES TO MEDICATIONS

MEDICATION	REACTION THAT OCCURS

CURRENT MEDICATIONS *(Additional Medication Sheet Can Be Provided)*

☐ SEE ADDITIONAL PAGE FOR MEDS

DRUG PRESCRIBED	DOSE (mg & X's per day)	M.D. PRESCRIBED