



Vein Treatment Institute

of Bucks County

David N. Brotman, M.D.

PATIENT GENERAL MEDICAL HISTORY

** The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Name : _____ Date Of Birth : _____ SS Number : _____

Marital Status: Single Married Divorced Widowed Occupation: _____ ? Retired

Allergies to Medications: _____

Current Medications: _____
(including herbals) _____

Current/Past Medical Problems (please circle) : ? Diabetes ? CAD/Heart Attack ? Congestive Heart Failure
and Operations: ? High Blood Pressure ? High Cholesterol ? COPD ? Blood Clots (DVT / PE)

Other: _____

Cardiologist _____ Neurologist _____ Podiatrist _____ Other _____

Smoking History: Never Still Not for _____ Years/Packs-per-day Smoked: ____/____

Alcohol History: Never Occasional Frequent Problematic Prior Alcoholism ? Drug Abuse

Family History: Blood Clots Abnormal Reactions to Anesthesia ? Cancer ?

Who? (M/F/GM/GF/Sis/Bro/Son/Dtr) _____

Systems Review: (Circle any that occur frequently or seem abnormal to you, or circle "none") None

General:	Abnormal sweating	Nighttime fever	Unexplained weight loss
Skin:	Changing or bleeding moles	Jaundice (yellowness)	
Breast:	Lump	Nipple discharge	
Blood/Lymph:	Enlarged lymph glands	Easy bruising/bleeding	
Cardiovascular:	Chest pain	Leg cramping with walking	Foot pain at night / with elevation
Respiratory:	Shortness-of-breath	Chronic cough	Bloody sputum
Gastrointestinal:	Diarrhea Constipation	Bloody bowel movements	Abdominal pain Vomiting
Urinary:	Burning with urination	Blood in urine Incontinence	Difficulty starting stream
Reproductive:	Abnormal menstruation	Vaginal discharge	Impotence
Endocrine:	Severe thirst	Nighttime urination	Heat/Cold intolerance
Neurologic:	Seizures	Numbness / Weakness	Sudden visual changes
Extremities:	Swelling Phlebitis	Heaviness	Blue or brown discoloration

The above information is true and correct to the best of my belief. _____

Your Signature

Date