SVAI
SHILOH VEIN & AESTHETICS INSTITUTE

Medical History Form

Name_____Date of Birth_____

Address_____Email_____

City_____ State_____ Zip Code_____

Cell Phone_____ Home Phone_____

Do you smoke Y or N if yes type/amount/how long_____

Do you drink alcohol Y or N type/amount/how long_____

Do you use illegal drugs Y or N type/amount/how long_____

Height_____ Weight_____ BP_____

List of current medications include aspirin or vitamins_____

_____

Do you currently, or have you ever had a problem in the following

Fever/ weight loss/gain	Y or N	Allergies	Y or N	Headaches	Y or N
Sinus Congestion	Y or N	Migraines	Y or N	Chronic Cough	Y or N
Seizures	Y or N	Asthma	Y or N	Loss of Vision	Y or N
Emphysema	Y or N	Blurred or Double Vision	Y or N	Diabetes	Y or N
Thyroid problems	Y or N	High Blood Pressure	Y or N	Heart Issues	Y or N
Vascular Disease	Y or N	Diarrhea	Y or N	Constipation	Y or N
Arthritis	Y or N	Joint Pain	Y or N	Muscle Pain	Y or N
Anemia/ Bleeding Issues	Y or N	Cancer	Y or N	Mental health Issues	Y or N

If yes please explain_____

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