Medical History Form (Veins)

UPDATE

Date: ______________________

Name (include Middle Initial): ____

Address: ____

City: ____________________________ **State:** _________ **Zip:** _______________________

DOB: __________________________ **SSN:** _______________________________

Home Phone: _______________________________

Cell Phone: _________________________________

Work Phone: ________________________________

Email: ____

Insurance: _____________________________________

Occupation: _________________________________ Full-time Part-time Retired Disabled

Employer: __________________________________ **Phone:** _____________________________

Marital Status: _______________________ **Full Name of Spouse:** ________________________

Spouse DOB: _________________________ **Spouse Employer:** ____________________________

Emergency Contact: ___________________________**Phone #:**____________________________

Primary Doctor: ____

Would you like us to send copies of your clinical information to your primary doctor? Y/N

How did you hear about us: ____

My symptoms include:

☐ Varicose veins __L __R

☐ Leg discomfort __L __R

aching	burning	dull
sharp	radiating	shooting
itching	tingling	throbbing

☐ muscle cramping	__L __R	☐ heaviness	__L __R
☐ fatigue/weakness	__L __R	☐ skin hard/tough	__L __R
☐ skin discoloration (tan)	__L __R	☐ dryness/flaking	__L __R
☐ edema/swelling	__L __R	☐ ulcers/wounds	__L __R
☐ leg restlessness	__L __R	☐ blood clots	__L __R
☐ inflammation/redness	__L __R	☐ bleeding	__L __R

My symptoms interfere with the following activities:

☐ working	☐ standing long periods	☐ sitting long periods
☐ shopping	☐ household chores	☐ sleeping
☐ lawn care	☐ childcare, eldercare	☐ driving
☐ walking	☐ exercise	☐ ____________________

To relieve discomfort, I have tried:

☐ regular exercise, such as walking	☐ weight
☐ elevating legs	☐ limiting salt intake
☐ wearing non-constrictive clothing	☐ avoid standing for long periods of time

☐ over the counter analgesics (Circle): Tylenol Aleve Ibuprofen Other:__________________

☐ compression stockings: knee high / thigh high how long(weeks/months)____________

Prescribed By: ____

Do you wear them consistently? Yes / No

Prior Medical Treatment or Testing:

- ☐ Sclerotherapy______________________
- ☐ Laser Ablation___________________
- ☐ Vein Stripping______________________
- ☐ Ultrasound______________________

Any other surgeries:

____
____
____

For the following section, please circle any of the following conditions you have a prior/current history with.

Cardiac/Vascular:	Comments/Surgeries:
Slow/Fast Breathing Hypertension High Cholesterol Pacemaker/Defibrillator Heart Attack Valve Problem/Murmur CHF Peripheral Vascular Disease	______________________________ ______________________________ ______________________________
Neurology: Dizziness/Fainting Migraines Stroke/TIA Paralysis Numbness/Tingling Vision Problems Seizures Speech Impediment	**Comments/Surgeries:** ______________________________ ______________________________
Respiratory: *Coughing/Wheezing* *Shortness of Breath Sleep Apnea* *COPD/Emphysema Bronchitis* *Asthma Pneumonia Sinusitis*	**Comments/Surgeries:** ______________________________ ______________________________

Other/Not Specified: (List in comments)	
<u>Musculoskeletal:</u> *Arthritis* Type(s): ________________________________ *Osteoporosis* *Cane/Walker/Wheelchair* Injuries: __________________________ Other/Not Specified: (List in comments)	<u>Comments/Surgeries:</u> ________________________________ ________________________________ ________________________________
<u>Renal/Endocrine:</u> *Kidney Problems* *Dialysis HD/CPD* *Diabetes I/II* *Thyroid Problems* Other/Not Specified (List in comments)	<u>Comments/Surgeries:</u> ________________________________ ________________________________ ________________________________
<u>Gastrointestinal:</u> *Stomach Ulcers* *Heartburn/GERD* *Nausea/Vomiting* *Diarrhea/Constipation* Other/Not Specified (List in comments)	<u>Comments/Surgeries:</u> ________________________________ ________________________________
<u>Genitourinary:</u> Pain/Burning Frequent Infections Prostate Problems Incontinence	<u>Comments/Surgeries:</u> ________________________________ ________________________________

Family History

Father	Age:	Alive/Expired	CAD	DM	HTN	
Mother	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	

***CAD - Cardiac Disease *DM – Diabetes *HTN – Hypertension (High Blood Pressure)**

Allergies: Specifically; IVP dye, Shellfish, Latex, Valium, or any drug in the "Caine" family

Medications, Food, Latex, or Environmental	**Reaction**

Medications:

Please include all supplements and over the counter medications:

Name	Dose	Frequency	Used to Treat

Please Bring Your Medication with You to The Office

Social History

- Do you smoke? Y/N ____pack per day/week for _____years. Quit - When? _______
- Drink any alcohol? Y/N ___ drink(s) _____times per week/month/year
- Illicit drug use? Y/N Type______________ Last used - ______________________
- Drink any caffeinated beverages? Y/N _____ cups per day/week Coffee/Tea/Soda
- Occupation:_________________________________ FT/PT Student/ Disabled/ Retired
- Marital Status: M /W / S / D Can we share medical information with your spouse? Y/N
- Diet (Circle): Regular Low-Sodium Low-Fat Low-Cholesterol ADA

  Other:___________________________
- Exercise: Never Rarely Occasionally Regularly→____days per week for at least ______min.

  Type of exercise: ____