Vein Treatment Center Health History

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Who is your Primary Care Physician? _____

Who referred you to our Clinic? _____ Date of last physical exam? _____

Current height _____ Weight_____ Reason for today's visit_____

Allergies to any medications or substances? _____

_____

List all current medications and dosages including any other the counter vitamins, herbal or dietary supplements:_____

_____

_____

Do you have a history of any of the following?

Heart condition Yes No Type of condition: _____

High blood pressure Yes No

Chronic lung condition Yes No Type of condition: _____

Do you require the use of oxygen Yes No _____liters CPAP or BiPAP Yes No Settings _____

Leg Swelling Yes No

Leg ulcers Yes No if yes location, treatment and outcome _____

Bleeding abnormalities Yes No Type of abnormality _____

Have you ever had a blood transfusion? Yes No Date of Transfusion: _____

Have you ever had a blood clot? Yes No Date: _____ Location of clot: _____

Treatment: _____

Do you wear support or compression stockings? Yes No How long have you worn support stockings?

_____

Have you noticed any improvement in your symptoms with the use of support/compression stockings?

Yes No Please explain: _____

Do you elevate your legs during the day or evening? Yes No How often? _____

Please turn the page to complete form

Do you exercise? Yes No What type of activity and how often? _____

_____

Do your varicose veins restrict your normal daily activities? Yes No How? _____

_____

Do your daily activities require periods of prolonged standing? Yes No

If yes, how often during the day do you need to sit or take a break due to leg symptoms?

Never once per day 2-3 times per day 4 or more times

Do you have pain related to your varicose veins symptoms? Yes No If yes, what medication do you take for the leg pain and how often? _____

Have you had previous veins procedures? Yes No Please specify type of procedure, location and date_____

_____

Outcome of procedure? _____

Please list any other previous surgical procedures and the dates of procedures: _____

_____

Do you use any of the following:			How much and how often?
Caffeine	Yes	No	_____
Tobacco	Yes	No	_____Quit date_____
Alcohol	Yes	No	_____
Street Drugs	Yes	No	_____

Are you currently pregnant? If yes estimated date of delivery _____

Any other significant information needed to assist in your care and medical decisions not otherwise listed: _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR OF ANY CHANGES TO MY HEALTH.

Signature of patient or guardian _____Date: _____