

MEDICAL HISTORY FORM



Name _____

Date _____ Age _____ Smoke _____

- | | | | |
|--|---|------------------------------------|----------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | Drug Allergies |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Superficial Phlebitis | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Seizures | |

Are you pregnant or nursing? ___Yes ___No ___N/A

Family Physician _____ Phone number _____

Surgical History (List all surgeries and approximate year) _____

List all medications you are currently taking _____

Symptoms

- | | | | | |
|--|---|---|---|---------------------------------------|
| <input type="checkbox"/> Aching or throbbing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Burning pain in legs | <input type="checkbox"/> Night cramps |
| <input type="checkbox"/> Tired or heavy legs | <input type="checkbox"/> Ankle/leg swelling | <input type="checkbox"/> Red/warm areas | <input type="checkbox"/> Varicose veins (bulging) | <input type="checkbox"/> Hard lumps |
| <input type="checkbox"/> Skin changes | <input type="checkbox"/> Ulcers or ulceration | <input type="checkbox"/> Itching | <input type="checkbox"/> Spider veins | <input type="checkbox"/> Other _____ |

Personal History of Varicose Veins or Spider Veins

_____ List number of years

- Y N Related to pregnancy
Y N Related to accident/trauma
Y N Are you developing new veins
Y N Are your present veins getting bigger
Y N Does your discomfort/leg pain interfere with your activities of daily living?
Y N Do you smoke?

Are your symptoms worse with:

- Y N Prolonged standing
Y N Prolonged seating
Y N Menstrual cycle

Are your symptoms relieved with:

- Y N Rest/Elevation of leg(s)

Family History of Varicose Veins or Spider Veins (please circle)

Mother Father Sister Brother Grandmother Grandfather Uncle Aunt None

Previous conservative treatment you have tried:

- Y N Have you ever worn compression stocking for your veins? When? _____
Y N Did they help your symptoms (leg pain/swelling)? Totally or Partially?
Y N Do you take pain medications (Advil, Tylenol, aspirin) for your leg pain/veins?

Previous Treatment History

- Y N Ligation/Stripping Surgery If so, which leg? _____ When? _____
Y N Injection Treatments If so, which leg? _____ When? _____
Y N Laser Therapy If so, which leg? _____ When? _____
Y N Other _____

Patient Signature _____ Date: _____