



Patient- Medical History

Name: _____ Date: _____
DOB: _____ Age: _____
Sex: M or F Occupation: _____
Family Physician: _____ Referred by: _____

Present Medical Problem (Chief Complaint)

Please describe briefly your present medical symptoms or problem: **R** **L** **Both** (circle)

Medications

Please list your medications including blood thinners, aspirin, hormones, herbal supplements, and birth control pills:

Medication Allergies

Social History

Do you smoke? Yes No If so, how many packs per day? _____
Do you drink alcohol? Yes No If so, how many drinks per week? _____

History of Present Illness

When did your symptoms first begin? _____

Have you experienced any of the following in your legs (circle all that apply)?

aching or pain	swelling	spider veins
varicose veins	leg cramps	bleeding from veins
heaviness /fatigue	calf pain when walking	leg pain when standing
itching or burning	pigmentation of the skin	ulceration
restless legs	dermatitis	easy bruising

Have you tried any of the following? Please indicate **when treatment started** and **whether treatment helped**.

Prescription support stockings _____
Any other type of support stockings or support hose _____
Leg elevation _____
Exercise _____
Weight loss _____
Occupation change _____
Pain medication _____

Have your veins gotten worse in recent months? Yes No

Does prolonged standing make your legs worse? Yes No

Do your symptoms interfere with walking? Yes No

Women only

Are you currently pregnant? Yes No
How many times have you been pregnant? _____
Have you had enlargement of varicose veins related to:
-pregnancy Yes No
-weight gain Yes No
-hormones or birth control pills Yes No
Do you have pelvic pain after prolonged standing? Yes No
Do you have varicose veins in the pelvic area? Yes No

Past Medical History- Veins

Have you ever had?
superficial blood clots (phlebitis) Yes No
deep blood clots (DVT) Yes No
blood clots in the lungs (embolism) Yes No
Have you ever had any of these treatments?
vein removal (phlebectomy) R L
vein stripping R L
vein tied off (ligation) R L
vein injection (sclerotherapy) R L
vein ablation (EVLT, laser or RF) R L

Past Surgical History

Please list the type and date of previous surgeries:

Review of Systems

Do you have ?
heart disease (Y/N) bleeding disorder (Y/N)
heart valve disease (Y/N) diabetes (Y/N)
arterial disease (Y/N) hepatitis (Y/N)
high blood pressure (Y/N) arthritis (Y/N)
lung disease (Y/N) auto-immune disease (eg lupus) (Y/N)
anesthesia problems (Y/N) keloids or excessive scar formation (Y/N)
HIV infection (Y/N)

Please list problems affecting any other medical systems:

Family History

Please list vein problems that affect your family members (varicose veins, spider veins, blood clots, or swollen legs):
father _____
mother _____
other _____