PATIENT HEALTH HISTORY FORM
VENOUS INSUFFICIENCY – NEW PATIENT

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F

Reason For Your Visit _____

Who Referred You To Our Office? _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS, TRYING NOT TO LEAVE ANY BLANK. DUE TO THE INSURANCE INDUSTRY'S NEED TO FULLY UNDERSTAND YOUR MEDICAL NEEDS, IT IS NECESSARY TO COMPLETE AS MUCH OF THIS FORM AS POSSIBLE. THIS WILL ALSO ASSIST OUR OFFICE IN ASSESSING YOUR PARTICULAR NEEDS FOR PROPER MEDICAL CARE.

PAST MEDICAL HISTORY

Have You Been Hospitalized In The Past? YES NO

IF YES, Please Specify When And The Reason Why_____

_____

_____

Have You Had Surgery Of Any Kind? YES NO

Please Specify: _____

_____

HISTORY OF PRESENT ILLNESS

Which Leg Is Bothersome To You? RIGHT LEFT EQUAL

Have You Ever Had Your Veins Evaluated Before? YES NO

If So, Where And When _____

Did You Have Any Tests On Your Veins? (I.E. Ultrasound) YES NO

Do You Wear Light Support Hose (EX: SHEER ENERGY) YES NO

If So, Do They Provide Relief? YES NO

Do You Wear Support Hose Prescribed By A Doctor? YES NO

Do They Provide Relief? YES NO

If No, And You Tried Them, Why Don't You Wear Them Now? _____

_____

Have You Ever Had Any Of The Following?

VEIN SURGERY	YES	NO	WHICH LEG?	RIGHT	LEFT
VEIN INJECTIONS	YES	NO	WHICH LEG?	RIGHT	LEFT
BLOOD CLOTS	YES	NO	WHICH LEG?	RIGHT	LEFT
PHLEBITIS	YES	NO	WHICH LEG?	RIGHT	LEFT

Do You Have Any Of The Following Symptoms?

ACHING/PAIN IN YOUR LEGS	Y	N	HEAVINESS	Y	N
TIREDNESS/FATIGUE	Y	N	ITCHING/BURNING	Y	N
SWOLLEN ANKLES	Y	N	LEG CRAMPS	Y	N
RESTLESS LEGS	Y	N	THROBBING	Y	N

Any Other Symptoms? _____

How Long Have You Had These Symptoms? _____

Does Walking Help The Discomfort? YES NO

Do You Stand Much At Work Y N How Long? _____

Do You Stand Much At Home Y N How Long? _____

How Do You Relieve The Discomfort In Your Legs? ELEVATE WALK

Do You Want An Operative Procedure To Try To Improve Your Leg Discomfort Caused By Your Varicose Veins?

Y N

CURRENT MEDICAL HISTORY

Do You Have Any Of The Following?

HEART DISEASE	Y	N	PACEMAKER	Y	N
LUNG DISEASE	Y	N	ANEMIA	Y	N
HEPATITIS	Y	N	ARTHRITIS	Y	N
LEG ULCER	Y	N	DIABETES	Y	N
ASTHMA	Y	N	THYROID	Y	N
HIGH BLOOD PRESSURE	Y	N			

Are You Currently Under The Care Of A Physician? Y N

If Yes, Please State What Physician And For What Reason:

_____

_____

_____

Please List All Current Medications (Prescription & Non-Prescription)

Medication	Dosage	How Often Do You Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Take Blood Thinning Medications? Y N

Do You Take Birth Control Pills Or Hormones? Y N

Do You Have Allergies? Y N

Please List:	How Do They Affect You? (Ex: Hives, Shortness of Breath)
_____	_____
_____	_____
_____	_____

Are You Allergic To Shellfish, Shrimp, or Any Other Form of Iodine (IVP Dye)?

YES NO

SOCIAL HISTORY:

Marital Status S M D W

What Is Your Profession? _____

Do You Smoke? Y N If Yes, How Much? _____

Do You Drink? Y N If Yes, How Much? _____

WOMEN ONLY: CHILD BEARING HISTORY:

Do You Think You Are Pregnant? Y N

How Many Times Have You Been Pregnant? _____

Do You Intend To Have Any More Children? Y N

Are You Currently Breastfeeding? Y N

FAMILY HISTORY:

It Is Important For Us To Know Your Family Medical History. Please Include If Any Family Member Has Experienced Varicose Veins, Spider Veins, Leg Ulcers, Congestive Heart Failure, Coronary Artery Disease, or Had Bypass Surgery.

Mother	Alive	Deceased	Age _____	Ailments _____
Father	Alive	Deceased	Age _____	Ailments _____
Brother	Alive	Deceased	Age _____	Ailments _____
Brother	Alive	Deceased	Age _____	Ailments _____
Sister	Alive	Deceased	Age _____	Ailments _____
Sister	Alive	Deceased	Age _____	Ailments _____
Children	Alive	Deceased	Age _____	Ailments _____
Children	Alive	Deceased	Age _____	Ailments _____

MD Signature _____Date _____