Intermountain
Utah Valley Vein Clinic

General Health History

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Referring Medical Provider: _____

Medical Conditions: (Indicate if you have had any of the following conditions)

Heart Disease:	No____ Yes ____	Bleeding Disorder:	No___ Yes ___
Diabetes:	No____ Yes ____	Blood Clots:	No___ Yes ___
Anxiety:	No____ Yes ____	Asthma:	No___ Yes ___

Other: _____

Medications and Vitamins Currently Taking: (Prescribed and Over the Counter)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Previous Surgeries:

_____
_____

Significant Injuries or Hospitalizations within last 2 years:

_____
_____

Medical Allergies and physical response (Ex. Sulfa – skin rash):

_____

Personal Habits:

Do you consume alcoholic beverages (type and frequency?_____
Coffee: _____ cups per day Tobacco (type and frequency): _____

Women Only: Are you pregnant? No __ Yes __ N/A __
Menstrual History: Date of last menstrual cycle: _____

Patient Health Systems Review: Circle symptoms experienced during the Last Year:

CNS	EENT	Skeletal	Heart / Respiratory	Skin
Headaches	Hard of Hearing	Backpain	Cough	Rashes
Dizziness	Dental Pain	Arthritis	Palpations	Boils
Convulsions	Nose Bleeds	Foot Pain	Fainting Spells	
Tremors			Chest Pain	
Paralysis			Shortness of Breath	
Numbness			Swollen Ankles	

GI		GU	Metabolism
Trouble Swallowing	Jaundice	Urinary Distress	Unusual Thirst
Abdominal Pain	Constipation	Urinary Stones	Unusual Perspiration
Heartburn or Ulcers	Diarrhea	Urinary Infection	Unusual Warmth
Vomiting/Nausea	Rectal Bleeding		

Family History: (Has any blood relative ever had any of the following conditions :)

Heart Trouble No_____ Yes _____ , If yes, their relationship to you: _____
Stroke No_____ Yes _____ , If yes, their relationship to you: _____
High blood pressure No_____ Yes _____ , If yes, their relationship to you: _____
Epilepsy No_____ Yes _____ , If yes, their relationship to you: _____
Varicose Veins No_____ Yes _____ , If yes, their relationship to you: _____
Leg Ulcers No_____ Yes _____ , If yes, their relationship to you: _____

Venous Health History

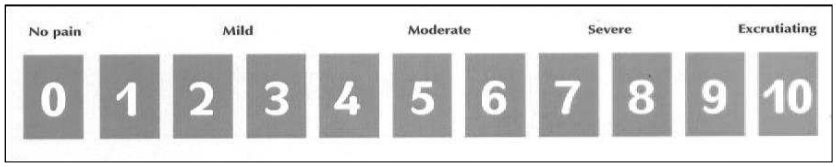
Directions: Please answer the following questions. Provide estimates for date of occurrence.

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections/sclerotherapy? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis (inflammation of vein)? ☐ Yes ☐ No
   If yes, which leg and when? _____
5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____
6. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____

1. Do you experience any of the following in your legs, left or right leg?

Symptom	Left – Right		Symptom	Left - Right	
Aching/Pain	☐	☐	Heaviness	☐	☐
Fatigue	☐	☐	Itching or burning	☐	☐
Ankle Swelling	☐	☐	Leg Cramps	☐	☐
Restless Legs	☐	☐	Leg Throbbing	☐	☐

PAIN Scale -Rate the intensity of pain (0 to 10)_____ Persistent ☐ Yes ☐ No



2. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication(s) do you take and how many times/mgs per day? _____
   _____

3. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief?_____

4. Do you wear prescription compression stockings? ☐ Yes ☐ No
   If yes, what type and gradient? How long have you worn them? _____
   _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

5. Do you have any problem walking? ☐ Yes ☐ No
   If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise)
   _____

6. What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours)_____
   _____

7. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
   If yes, when and what type of test and where on the leg? _____
   _____
   Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

Patient Signature: _____Date:_____