

ADVANCED VEIN CENTER MEDICAL HISTORY

Date: _____ Acct # _____

Last Name : _____ First Name: _____

DOB: __/__/__ AGE: __ Sex: M / F Race: _____

Primary Physician: _____

Medication Allergies: Drugs Iodine

Other: _____

Vital Signs: B/P _____ P _____ R _____ Weight: _____

VEIN HISTORY:

What is the reason why you are seeking treatment? Cosmetic or Medical

Have you seen any other doctors for treatment of your veins? Yes or No

If yes, explain: _____

Do you or have you ever worn compression stockings? Yes or No How Long? _____

If yes, please list what type you used? _____ Did they help? Yes or No

Have you ever had a blood clot in your leg? Yes or No When? _____ Which Leg? Right or Left

Any bleeding due to Varicose Veins? If yes, when ? _____

Any leg ulcers ? If yes, when? _____ where? _____

Do You experience any of the following symptoms in your legs?

- Aching / Pain Yes or No If yes, how long? _____
- Heaviness Yes or No If Yes, How long? _____
- Tiredness / Fatigue Yes or No If yes, how long ? _____
- Itching / Burning Yes or No If yes, how long ? _____
- Swollen ankles Yes or No If yes, how long ? _____
- Leg Cramps Yes or No If yes, how long? _____
- Throbbing Yes or No If yes, how long? _____
- Restless legs Yes or No If yes, how long? _____

Any other leg symptoms? _____

Do you have problems walking? Yes or No

If yes, explain: _____

Are your symptoms worse at the end of the day? Yes or No

Are the problems you are having in your legs interfering with your lifestyle? Yes or No

PAST MEDICAL HISTORY: (CIRCLE)

Diabetes Stroke/TIA Trauma to legs Other: _____
Cancer Arthritis / Gout Heart Murmur Heart disease

PAST SURGICAL HISTORY: (CIRCLE)

Heart catheterization Heart stent/balloon Heart Bypass Heart valve surgery
Other: _____
Pacemaker / AICD Carotid surgery Leg bypass / stent Prostate surgery
Varicose Vein Surgery/Stripping Peripheral Vascular Disease HTN

FAMILY HISTORY: (CIRCLE) Varicose Veins Clots in legs Vascular disease

SOCIAL HISTORY: (CIRCLE)

If you have ever smoked, how many years? _____ How many packs? _____
Have you quit? _____ If yes, what year? _____
Do you drink alcohol frequently? _____ How much and how often? _____
History of Drug abuse? Yes or No If so, what drug, and for how long? _____
Do you exercise? Yes or No If yes, describe: Bicycle Walk Jog Treadmill Other
How long? ____Mins _____ Miles
Occupation: _____
Does your job involve prolonged standing or sitting? Yes or No

OBGYN HISTORY:

Previous pregnancies? Yes or No If yes how many? _____
Are you taking Oral Contraceptives? Yes or No If yes, what? _____
Do your symptoms vary with your menstrual cycle? Yes or No

SIGNATURE: _____ Date: _____