



Venous Medical History Form

MRN(Office Use Only): _____

Full Name _____ Date of birth ____/____/____

Patient Social Security #: ____/____/____ Sex: M____ F____

Street Address: _____

City/State: _____ Zip Code: _____

Patient's Home Phone: (____) _____ Daytime Phone: (____) _____

E-mail Address: _____

How did you hear about us?

Website Family/Friend Newspaper Women's Fair Magazine

Phone Book Physician Referral

Other (Please Explain): _____

Employer: _____

Occupation: _____

Name of Primary Care Physician: _____

Chief Complaint: _____

Are you consulting for: Medical Y ___ N ___ Cosmetic Y ___ N ___ Both _____

How long have you noticed the veins you are concerned about? _____

When did your vein problems begin to occur?

Age: _____

Before pregnancy? Y ___ N ___

During pregnancy? Y ___ N ___

Total number of pregnancies? _____

Total number of deliveries? _____

After trauma? Y ___ N ___

After birth control/estrogen therapy? Y ___ N ___

Are you currently taking any hormone replacement therapy? Y _____ N _____

Are you developing new problematic veins? Y _____ N _____

Are your present veins getting bigger/worse? Y _____ N _____

Which of the following have you experienced?

Pain in the:	Right leg		Left leg		Number of years
Foot:	Y	N	Y	N	_____
Ankle:	Y	N	Y	N	_____
Calf:	Y	N	Y	N	_____
Thigh:	Y	N	Y	N	_____
Whole leg:	Y	N	Y	N	_____
Swelling:	Y	N	Y	N	_____
Aching/heaviness:	Y	N	Y	N	_____
Night Cramps:	Y	N	Y	N	_____
Resting Cramps:	Y	N	Y	N	_____
Redness/inflammation:	Y	N	Y	N	_____
Burning sensation:	Y	N	Y	N	_____
Skin/ulcer problems:	Y	N	Y	N	_____

If you experience leg pain, is it made worse by:

	YES	NO
Prolonged sitting/standing	_____	_____
Heat	_____	_____
Menstrual Periods	_____	_____
Exercising/walking	_____	_____
Medication	_____	_____

Is the pain improved by:

	YES	NO
Leg Elevation	_____	_____
Walking	_____	_____
Anti-Inflammatory Medications	_____	_____
(Advil, Motrin, Aleve), if used, for how long?	_____	
Elastic Stockings	_____	_____
If you have worn stockings, for how long?	_____	
If you have worn stockings, what kind?	_____	
Did they help?	_____	

Family History (list family member below)

Varicose Veins: _____	Yes _____	No _____
Phlebitis (vein inflammation): _____	Yes _____	No _____
Blood clots: _____	Yes _____	No _____
Leg Ulcers: _____	Yes _____	No _____
Blood coagulation disorders _____	Yes _____	No _____

Have you ever been treated for your veins? _____

Which leg? Right _____ Left _____

When? _____

What Method?(circle all that apply) Injection Radiofrequency Laser Surgery

Have you been treated for:

Phlebitis (vein inflammation)?

Right leg _____ Left leg _____

Hospitalization? _____

Coumadin Anticoagulation? _____

Leg Ulcer?

Right leg _____ Left leg _____

Hospitalization? _____

Deep Venous Thrombosis/Pulmonary Embolism?

Hospitalization? _____

Coumadin Anticoagulation? _____

Leg Fracture?

Right leg _____ Left leg _____

Leg / Joint Surgery?

Right leg _____ Left leg _____

Past Medical History:

Do you have or have you had any medical conditions? (e.g. heart disease, diabetes, high blood pressure, stroke, blood clots or heart attack, ulcers, or cancer.)

Past Surgical History (previous surgical procedures) Please list and date

Procedure	Year
_____	_____
_____	_____
_____	_____

Medications: (Please include BCP, and Estrogen Replacement Therapy.)

Name	Dosage(mg/strength)	# times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications?

Medication	Reaction
_____	_____
_____	_____
_____	_____

Social History

Are you employed? Yes No

Type of work: _____

Does your work require:

Prolonged Standing Yes _____ No _____

Prolonged Sitting Yes _____ No _____

In a normal day, time spent standing? 10% 25-50% >50%

Do you smoke? Yes _____ No _____

If yes, maximum number of packs per day? _____

For how many years? _____

List alcohol intake amount and frequency: _____



Venous Medical History Form – Review of Systems

Do you now, or have you had any problems related to the following body systems?
Please check yes or no, and explain in the space provided.

General Symptoms:			Comments	Skin:			Comments
Yes	No			Yes	No		
Fever				Rash			
Chills				Boils			
Weight loss				Itching			
Vision / Eyes:			Comments	Musculoskeletal:			Comments
Yes	No			Yes	No		
Blurring				Joint pain			
Doubling				Neck pain			
Blindness				Back pain			
Allergy / Immune:			Comments	Ear-Nose-Throat:			Comments
Yes	No			Yes	No		
Hay fever				Infection			
Drug allergy				Sinus problem			
Other				Snoring			
Neurologic:			Comments	Genitourinary:			Comments
Yes	No			Yes	No		
Tremors				Incontinence			
Dizziness				Painful void			
Numbness				Frequency			
Stroke				Difficulty			
TIA							
Gastrointestinal:			Comments	Respiratory:			Comments
Yes	No			Yes	No		
Abdominal pain				Wheezing			
Nausea				Persistent cough			
Vomiting				Short of breath			
Heartburn				Winded easily			
Appetite loss							
Bloody stool							
Heart:			Comments	Blood / Lymph:			Comments
Yes	No			Yes	No		
Chest pain				Easy bruising			
Heart attack				Bleeding			
Palpitations				Blood clots			
Passing out				Swollen glands			
Psychological:		Yes	No	Comments			
Are you satisfied with life?							
Are you depressed?							
Have you been suicidal?							
Physician use: (Comments / Notes)							