Today's Date:____________________

Patient History Form

Name:__________________________Date of Birth:____________________Occupation:______________

Chief Complaint: Please describe the problems you are experiencing.

____

____

____

Current or past symptoms:

YES	NO	
❑	❑	Leg pain or discomfort
❑	❑	Legs feeling heavy
❑	❑	Leg cramps
❑	❑	Leg burning, itching
❑	❑	Leg swelling

YES	NO	
❑	❑	Restless legs
❑	❑	Enlarged leg veins
❑	❑	Skin color changes on the leg
❑	❑	Blood clots, DVT, or phlebitis
❑	❑	Leg ulcerations

❑ ❑ **Are any of these symptoms worse with prolonged standing or sitting?**
❑ ❑ **Have you had any vein procedures in the past (surgical or cosmetic)?**

Please list your current medications:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Medication Allergies:

____
____
____

YES	NO	
❑	❑	Smoker? _________Packs per day? ________Years?_________________
❑	❑	Former Smoker? When did you quit?______________________________
❑	❑	Drink alcohol? If yes, how many times in the past year have you had 4 or more alcoholic drinks in a day?______________________________________

Height: _________

Weight: _________

Please Circle:

Mother: Alive / Deceased
Father: Alive / Deceased

Women only—Date of last menstrual period______________________________

YES	NO	
❑	❑	Do you have a history of varicose veins of the vulva?
❑	❑	Do any of your leg/vein symptoms change with your period?
❑	❑	Do you have pain after intercourse?
❑	❑	Do you have pelvic pain?

If yes, do your symptoms get better after lying down? ❑**YES** ❑**NO**

Men only_ Do you have a history of varicose veins of the scrotal area? ❑ **YES** ❑ **NO**

Family History: Have any of your family members had:

YES	NO		
❑	❑	Vein stripping or vein surgery?	If yes, who? ______________________________
❑	❑	Varicose veins?	If yes, who? ______________________________
❑	❑	Blood coagulation disorder?	If yes, who? ______________________________
❑	❑	Blood clots?	If yes, who? ______________________________
❑	❑	Stroke or heart attack?	If yes, who? ______________________________
❑	❑	Pulmonary embolism?	If yes, who? ______________________________

List any past surgeries and the approximate year:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Please check if you have any of the following:

❑High blood pressure	❑History of heart attack	❑Chest pain
❑Heart murmur	❑Irregular heart beat	❑Artificial heart valve
❑Peripheral vascular disease	❑Congestive heart failure	❑Diabetes
❑Kidney disease	❑Cancer	❑Epilepsy/Seizure
❑Arthritis	❑Mental illness	❑Emphysema
❑Asthma	❑Shortness of breath	❑Artificial Joints
❑Wheezing	❑Stroke	❑High Cholesterol
❑Thyroid disease	❑Seasonal allergies	❑Bleeding disorder
❑Gastrointestinal disease	❑Liver disease/Hepatitis	❑HIV

- **Date of last flu vaccine:**____
- **Date of last pneumonia vaccine:**_______________________________________
- **Date of last mammogram (women):**_____________________________________
- **Date of last colonoscopy:**____

Clinician signature:_______________________________________**Date:**__________________