

Patient Health History Form

Name: _____ Date: _____

Age: _____ Sex: M/F

Directions: Please answer the following questions, trying not to leave any blank spaces.

Past Medical History

- | | | |
|-----------------------------------------------------|-----|----|
| 1. Have you ever been in the hospital as a patient? | Yes | No |
| If yes, for what reason _____ | | |
| 2. Have you ever had surgery? | Yes | No |
| If yes, what type of surgery and when? _____ | | |
| 3. Have you ever had vein stripping surgery? | Yes | No |
| If yes, when and which leg? _____ | | |
| _____ | | |
| 4. Have you ever had vein injections? | Yes | No |
| If yes, when, where, and which leg? _____ | | |
| _____ | | |
| 5. Are you presently under the care of a physician? | Yes | No |
| If yes, for what illness or purpose? _____ | | |
| _____ | | |
| 6. Do you have heart disease? | Yes | No |
| lung disease | Yes | No |
| high blood pressure | Yes | No |
| hepatitis | Yes | No |
| arthritis | Yes | No |
| leg ulcer | Yes | No |
| 7. Have you ever had a blood clot? | Yes | No |
| If yes, which leg and when? _____ | | |
| 8. Have you ever had phlebitis? | Yes | No |
| If yes, which leg and when? _____ | | |

Child Rearing History

- | | | |
|---------------------------------------------|-------|----|
| 1. Do you think you are presently pregnant? | Yes | No |
| 2. How many times have you been pregnant? | _____ | |
| 3. Do you intend to have any more children? | Yes | No |
| 4. Are you presently breastfeeding? | Yes | No |

Please *circle* the appropriate answer.

Family

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

Father	Yes	No
Mother	Yes	No
Brother(s)	Yes	No
Sister(s)	Yes	No
Other _____		
1. Do you experience any of the following?		
a. Aching/pain in your legs?	Yes	No
b. Heaviness	Yes	No
c. Tiredness/fatigue	Yes	No
d. Itching/burning	Yes	No
e. Swollen ankles	Yes	No
f. Leg cramps	Yes	No
g. Restless legs	Yes	No
h. Throbbing	Yes	No
i. Other _____		
2. Have your veins gotten worse in recent months?	Yes	No
3. Do you elevate your legs to relieve discomfort?	Yes	No
4. Do you wear support hose prescribed by a doctor	Yes	No
If yes, what type? _____		
5. Do you wear light support hose (eg. sheer energy)?	Yes	No
6. Do they provide relief?	Yes	No
7. Do you have any problem walking?	Yes	No
If yes, how does it affect you? _____		
8. Do you stand much at work?	Yes	No
at home?	Yes	No
9. How does this standing affect your legs?		

10. Do you smoke?	Yes	No
If yes, how many packs per day? _____		
11. Have you ever had your veins evaluated before?	Yes	No
If so, when and where? _____		
12. Have you ever had any test(s) done on your veins?	Yes	No

Current Medical History

1. Do you have any allergies (medicines, food, pollen, etc.) Please list them and briefly describe your reaction (eg. rash, hives, shortness of breath, etc.)	Yes	No

2. Are you allergic to shrimp or shellfish (or any form of iodine, IVP dye)?	Yes	No
3. Are you presently taking any medication including prescription and/or non-prescription (over-the-counter) medicines (aspirin, vitamins)?	Yes	No
If so, list them. _____		

4. Do you take any blood-thinning medication?	Yes	No
5. Are you taking hormones or birth control pills?	Yes	No
If yes, please list name(s). _____		
