Medical History Form

Name: _____

Date: _____ /_____ /_____ **Age:** _____ **Smoke** (Years): _____

☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis Drug Allergies
☐ Mitral Valve Prolapse ☐ Bleeding Disorder ☐ Stroke _____
☐ Open Heart Surgery ☐ Pulmonary Embolus ☐ Diabetes _____
☐ Superficial Phlebitis ☐ Deep Vein Thrombosis ☐ Seizures _____

Are you pregnant or nursing? _____Y _____N _____N/A

Family Physician: _____ Phone number: (____)_____-_____

Surgical History (List all surgeries and approximate year)

_____

_____

_____

List all medications you are currently taking _____

_____

_____

_____

Symptoms:

☐ Aching or throbbing ☐ Leg pain ☐ Red/warm areas ☐ Spider veins
☐ Tired or heavy legs ☐ Ankle/leg swelling ☐ Itching ☐ Night cramps
☐ Skin changes ☐ Ulcers or ulceration ☐ Burning pain in legs ☐ Hard lumps
☐ Leg pain ☐ Tenderness ☐ Varicose veins (bulging) ☐ Other_____

Personal History of Varicose Veins or Spider Veins:

_____ **List number of years**

Y N Related to Pregnancy?
Y N Related to Accident Trauma?
Y N Are you developing new veins?
Y N Are your present veins getting bigger?
Y N Do you smoke?
Y N Does your discomfort/leg pain interfere with your activities of daily living?

Are your symptoms worse with:

Y N Prolonged standing?
Y N Prolonged seating?
Y N Menstrual cycle?

Are your symptoms relieved with:

Y N Rest/Elevation of leg(s)?

Family History of Varicose Veins or Spider Veins:

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Uncle ☐ Aunt ☐ None

Previous Treatment History:

Y N Ligation/Stripping Surgery If so, which leg? _____ When? _____
Y N Injection Treatments If so, which leg? _____ When? _____
Y N Laser Therapy If so, which leg? _____ When? _____
Y N Other_____

Patient Signature_____ **Date:** _____ /_____ /_____