



MEDICAL HISTORY

YES/NO PLEASE CHECK

- High Blood Pressure
- Heart Disease
- Phlebitis

YES/NO

- Pulmonary Embolus
- Bleeding Disorder
- Blood Clots

YES/NO

- Hepatitis
- Seizures
- Diabetes

Other _____

Surgical History (LIST ALL SURGERIES) _____

Medications you are taking _____

Are you on hormone therapy; estrogen, premarin, provera, birth control etc.? _____

Are you pregnant or actively trying to get pregnant? YES NO

Allergies / Sensitivities (drugs and foods) _____

- Do you have ?** (Please Check)
- | | | |
|---|---|--|
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Tired / Heavy Legs | <input type="checkbox"/> Skin Changes |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Red / Warm Areas |
| <input type="checkbox"/> Aching / Throbbing | <input type="checkbox"/> Itching | <input type="checkbox"/> Ulcers / Ulceration |
| <input type="checkbox"/> Burning / Stinging | <input type="checkbox"/> Swelling | <input type="checkbox"/> Other _____ |

How many years have you had this problem? _____ years

YES/NO PLEASE CHECK

- Related to Pregnancy?
- Related to a Leg Injury?
- Are you developing New Veins?
- Are your present veins getting bigger?
- Is your discomfort/pain getting worse?
- Do you ever take any medication for your leg pain/veins?
aspirin, advil, motrin, ibuprofen, other
- Does your discomfort/leg pain interfere with your activities of daily living?
- Have you ever worn stockings for your veins? For How Long?
- Did they help your symptoms (leg pain / swelling)?
- Have you ever seen another physician about your veins?

Are your symptoms worse with?

- prolonged standing / sitting
- menstrual cycle
- not baths or saunas

Are your symptoms relieved with?

- rest / elevation of leg

For How Long?

PHYSICIANS NAME _____

Additional comments: _____

Family History of Varicose Veins / Spider Veins / Phlebitis / Blood Clots (Please circle which relatives have had any of these.)

mother father sister brother grandmother grandfather uncle aunt none

Previous Vein Treatment History:

- Surgery
- Laser
- Injections
- Other _____

Family Physician _____ **phone number:** _____

Address: _____

Who referred you to our office? _____

By signing below, I also consent to the taking of photographs for my medical records.

Patient's Signature

Date