# Medical History Form

**Name:**

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**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 Venous Thrombosis
- Seizures

**Are you pregnant or nursing?** ______ Y ______ N ______ N/A

**Family Physician:** ____________________________  **Phone number:** (______)_______-________

**Surgical History** (List all surgeries and approximate year)

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**List all medications you are currently taking**

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**Symptoms:**

- Aching or Throbbing
- Leg Pain
- Red/warm areas
- Spider Veins
- Tired or heavy legs
- Ankle/leg Swelling
- Restless Legs
- Skin changes
- Night Cramps
- Ulcers or ulceration
- Burning pain in legs
- Hard lumps
- Itching
- Tenderness
- Varicose veins (bulging)
- Other

**Personal History of Varicose Veins or Spider Veins:**

<table>
<thead>
<tr>
<th>List number of years</th>
<th>Are your symptoms worse with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N Related to Pregnancy?</td>
<td>Y N Prolonged standing?</td>
</tr>
<tr>
<td>Y N Related to Accident Trauma?</td>
<td>Y N Prolonged sitting?</td>
</tr>
<tr>
<td>Y N Are you developing new veins?</td>
<td>Y N Menstrual cycle?</td>
</tr>
<tr>
<td>Y N Are your present veins getting bigger?</td>
<td>Are your symptoms relieved with?</td>
</tr>
<tr>
<td>Y N Do you smoke?</td>
<td>Y N Rest/Elevation of leg (s)?</td>
</tr>
</tbody>
</table>

**Family History of Varicose Veins or Spider Veins:**

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

**Patient Signature** ____________________________  **Date:** _______ / _______ / _______
Medical History Form

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

Previous conservative treatment you have tried:

Y  N  Do you take pain medications (Advil Tylenol Aspirin) for your leg pain/veins?
Y  N  Have you worn compression hose or active support hose for your current problem for 6 months or longer?
When? _____________________________________
Y  N  Did they help your symptoms (leg pain/swelling)? Totally Partially
Y  N  Have you been taking over the counter anti-inflammatory medications for 6 months or longer for leg pain?
Y  N  Do you routinely rest and elevate your legs to help relieve leg pain and/or swelling?
Y  N  If yes, have you done so for 6 months or longer?
Y  N  Has your varicose vein problem caused a physical impairment due to pain, swelling, throbbing, tired feelings, etc.?

What specifically do you feel you can no longer do because of your varicose veins?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Y  N  Have you discussed your varicose vein problem with your primary care doctor or any other doctor?
If so, what did the doctor recommend that you do?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

What have you tried on your own to help alleviate your symptoms, beyond what you have already indicated?
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

How did you hear about us?

[ ] Friend  [ ] Newspaper  [ ] Doctor  [ ] Other__________________________
[ ] Magazine  [ ] Internet  [ ] Relative

Patient Signature__________________________________________________ Date: _______ /_______ /______