Vein associates

MEDICAL HISTORY

Name: _____ Date of Birth: _____

Check reason(s) for visit: ☐ Varicose Veins ☐ Spider Veins ☐ Hemorrhoids

Name of Primary Care Physician: _____

History:

1. When did you first notice the above problem(s)? _____

2. Have you seen another physician for this problem? ☐ Yes ☐ No
   If yes, who: _____ When: _____
   What treatment/testing was recommended: _____
   Was treatment/testing done: ☐ Yes ☐ No

3. List any significant illnesses for which you are *currently* under a physician's care:
   _____
   _____

4. Medication allergies: Penicillin: ☐ Yes ☐ No
   Local Anesthetic: ☐ Yes ☐ No
   Other: _____

5. List current medications, both prescription and non-prescription, including birth-control pills, aspirin, herbs, etc. and dosages: _____
   _____
   _____

6. List previous operations including cosmetic surgery: _____
   _____
   _____

7. Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____
   Do you smoke? ☐ Yes ☐ No If so, how much? _____

8. Are you pregnant or planning a pregnancy soon? ☐ Yes ☐ No

9. Do you have a pacemaker? ☐ Yes ☐ No

10. Have you ever been diagnosed with any of the following:

HIV	☐ Yes	☐ No	Details: _____
Hepatitis or other Liver Disease	☐ Yes	☐ No	Details: _____
Bleeding disorder	☐ Yes	☐ No	Details: _____
Benign or malignant tumor	☐ Yes	☐ No	Details: _____
Diabetes	☐ Yes	☐ No	Details: _____
High Blood Pressure	☐ Yes	☐ No	Details: _____
Heart Disease or Stroke	☐ Yes	☐ No	Details: _____
Kidney disease	☐ Yes	☐ No	Details: _____
Asthma	☐ Yes	☐ No	Details: _____
Inflammation of a vein (phlebitis)	☐ Yes	☐ No	Details: _____
Blood clot in the legs	☐ Yes	☐ No	Details: _____
Blood clot in the lungs	☐ Yes	☐ No	Details: _____
Stomach or Intestinal Ulcers	☐ Yes	☐ No	Details: _____
Crohn's Disease	☐ Yes	☐ No	Details: _____
Rectal Bleeding	☐ Yes	☐ No	Details: _____
Black Tarry Stools	☐ Yes	☐ No	Details: _____
Constipation or Diarrhea	☐ Yes	☐ No	Details: _____
Change in Bowel Habits	☐ Yes	☐ No	Details: _____
Family History of Colon Cancer	☐ Yes	☐ No	Details: _____
Neurological Disease or Epilepsy	☐ Yes	☐ No	Details: _____
Depression or Emotional Problems	☐ Yes	☐ No	Details: _____

Other (please specify): _____

Prior Tests Performed:

Ultrasound of Veins	☐ Never	☐ Yes	Date:	_____	Results:	_____
Rectal Exam	☐ Never	☐ Yes	Date:	_____	Results:	_____
Stool Occult Blood.....	☐ Never	☐ Yes	Date:	_____	Results:	_____
Sigmoidoscopy	☐ Never	☐ Yes	Date:	_____	Results:	_____
Colonoscopy.....	☐ Never	☐ Yes	Date:	_____	Results:	_____

Review of Symptoms:

Legs (Varicose or Spider Veins):

Aching.....	☐ Yes	☐ No
Itching.....	☐ Yes	☐ No
Numbness or Tingling.....	☐ Yes	☐ No
Fullness or Pressure.	☐ Yes	☐ No
Swelling.....	☐ Yes	☐ No
Leg Restlessness.....	☐ Yes	☐ No
Muscle Cramping	☐ Yes	☐ No

Rectum (Hemorrhoids):

Itching	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No
Protrusions	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

I hereby certify that the information supplied on this form is accurate.

Patient: **X**_____

Date: __/___/_____