Exclusive Vein Care

Medical History

Name:________________________ Date:_______________ Age:________________

Email address:___________________________

Emergency contact/relationship:______________________

Circle any of the medical issues if you have or have had

Anemia/Blood disorder	Anxiety	Arthritis/Orthopedic issues
Asthma/emphysema	Atrial Fibrillation	Back problems
Bleeding/clotting problems	Cancer	Chemotherapy/Radiation
Deep vein thrombosis (DVT)	Defib/Pacemaker	Depression
Diabetes	Scarring (Keloids)	Fear of needles
Heart attack	Heart disease	Heart valve disorder
Hepatitis	High blood pressure	Liver disease
Lung disease/COPD	Lupus	Migraine headaches
Phlebitis	Pigmentation prob	Poor wound healing
Problems that limit walking	Stroke/TIA	Thyroid disorder
Urinary problems		

Women: Number of pregnancies____ Currently pregnant or breastfeeding?_____

Primary care or other regularly consulted physician(s)___________________________________

____

Do you smoke? Never___ No____ Yes____ Currently____ Discontinued when?______

Do you drink alcohol? No____ Yes____ Amount If yes, glasses/day or week? _______

Details of medical history

____

____

Surgical History List type of surgery and approximate date.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Medical History, page 2

Patient name:_______________________ Date:____________________

Allergies

Any drug allergies or sensitivities?-list the drug(s) and type of allergy or sensitivity

____

____

Any contact allergies such as tape, Band Aids, latex?-list items

____

Medication List

Name of medication Dose/frequency Prescriber

____

____

____

____

____

____

____

Vein Problems-history

Varicose veins (large veins) Circle location: Right leg Left leg Both legs Other locations

Spider veins (small veins): Circle location: Right leg Left leg Both legs Other locations

Vein related symptoms-Circle any symptoms (Be aware that varicose or spider veins do not have to be visible to cause these symptoms.)

Pain Aching Bleeding Heaviness Itching Leg cramps Foot cramps Leg and/or foot swelling

Foot pain including heel spur/plantar fasciitis pain Numbness Pressure Phlebitis Throbbing

Restless legs Tingling Tired legs Persistent rash on lower leg Brown discoloration of the leg(s)

When did your symptoms start?____

Did your symptoms start with (circle which ones)? Physical trauma Pregnancy

Do any family members have varicose veins?____________________________________

Do your legs feel better when you elevate them?__________________________________

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Medical History, page 3

Name________________________________

Have you worn prescribed compression hose?_________ If yes, did they help?________________

Do you take any medications, OTC or prescribed, for vein related symptoms?____________________

Have you had any vein treatments in the past-circle which? Injections/Sclerotherapy Endovenous laser or radiofrequency ablation Vein removal-phlebectomy Vein glue If yes, when?__________________

Details of vein treatments____

List any activities that are limited by your symptoms. These may include walking, standing or sitting at work or doing chores at home, shopping, child care, etc.

____

Space for additional notes concerning any pertinent information not noted elsewhere.