Patient Health History Form

Varicose Veins Patients Only

Name: _____ Date: _____

Age: _____ DOB: _____ Sex: ☐M ☐F

Email: _____

Primary Care MD: _____

How did you hear about us? _____

Current Problem

How long have you had vein problems? _____

Have you ever had vein surgery? ☐Yes ☐No

What type of surgery and on which leg?

_____

_____

_____

Have you ever had vein injections (Sclerotherapy)? ☐Yes ☐No

If yes, which legs? ☐Right ☐Left

Do you currently have any of the following?	Right leg	Left leg
Spider veins	☐Y ☐N	☐Y ☐N
Large veins (varicosities)	☐Y ☐N	☐Y ☐N
Skin discoloration	☐Y ☐N	☐Y ☐N
Skin ulcers	☐Y ☐N	☐Y ☐N

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Do you have any tender areas on your leg? ☐Yes ☐No

Where? _____

Do you have any of the following symptoms? If yes, how severe are they on a scale of 1 to 10? (Please check a number on the line for the severity of the symptom)

Right Leg

	Minimal									Severe
Achiness	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Throbbing	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Fatigue	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Heaviness	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Itching/Burning	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Swelling	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Left Leg

	Minimal									Severe
Achiness	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Throbbing	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Fatigue	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Heaviness	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
Itching/Burning	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Swelling ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Have you ever had a blood clot in your leg? ☐Yes ☐No

If yes, which leg and when?

Past Medical History

Height: _____ Weight: _____

Do you have any medical problems? (Example: diabetes, high blood pressure)

Please list all prior surgeries and when they were performed:

List any medications you are allergic to:

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Are you taking any medications? ☐Yes ☐No

If yes, please list each one and include the daily dosage:

_____

_____

_____

Social History

What is your occupation and does it involve of lot of standing?

_____

_____

Do you smoke? ☐Yes ☐No Quit? _____ years ago

If yes, how much: _____ pack/day

Alcohol use (circle one): ☐No ☐Socially ☐1 drink/day ☐>1 drink/day

Family History

Mother Age: _____ Medical Conditions: _____

Father Age: _____ Medical Conditions: _____

Brothers #: _____ Medical Conditions: _____

Sisters #: _____ Medical Conditions: _____

Children

Sons #: _____ Medical Conditions: _____

Daughters #: _____ Medical Conditions: _____

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Symptoms

Please list any relevant symptoms that you currently have or have had in the past:

General
☐Fever
☐Chills
☐Pruritis (Itching)
☐Fatigue
☐Weight Loss

Skin
☐Lesions
☐Skin cancer
☐Psoriasis
☐Eczema

Ears
☐Decreased hearing
☐Ringing
☐Dizziness
☐Pain

Eyes
☐Visual changes
☐Infection
☐Tearing
☐Dry eyes

Nose
☐Bleeding
☐Allergies
Nasal polyps

Mouth
☐Dental problems
☐Change in taste
☐Dentures
☐Dry mouth
☐TM joint problems
☐Hoarseness
☐Swallowing pain

Neck
☐Thyroid problems
☐Lumps, masses

Breasts
☐Masses
☐Discharge
☐Pain

Respiratory
☐Shortness of breath
☐Asthma
☐COPD
☐TB
☐Bronchitis
☐Wheezing
☐Cough
☐Chest tightness
☐Pulmonary embolus
☐Excessive snaring
☐Sleep apnea

Cardiovascular
☐Hypertension
☐Chest pain
☐Angina
☐Heart Attack
☐Angioplasty
☐Murmur
☐Rapid heart beat
☐Fainting
☐Leg swelling

Peripheral vascular
☐Pain with walking
☐Leg cramping

Abdominal
☐Pain
☐Nausea/vomiting
☐Change in bowel habits
☐Diarrhea
☐Constipation
☐Blood in stool
☐History of polyps
☐Pancreatitis
☐Gallstones
☐Appendicitis
☐Irritable bowel
☐Inflammatory bowel
☐Hepatitis
☐Hernias
☐Hemorrhoids

Sexual history
☐Decrease libido
☐Sexual difficulties
☐Erectile dysfunction
☐Painful intercourse
☐Infertility issues

GU (men and women)
☐Urgency
☐Frequency
☐Burning
☐Flank pain
☐Bladder pain
☐Blood in urine
☐Kidney Stones
☐Urinary tract infection
☐Incontinence

GU (women)
☐Irregular menses
☐Painful periods
☐Hot flashes
☐Pregnancy loss

Extremities - muscle joints
☐Joint pain
☐Morning stiffness
☐Joint injuries
☐Limb swelling
☐Muscle pain
☐Back pain
☐Neck pain
☐Herniated disc

Neurologic
☐Seizures or epilepsy
☐Stroke
☐Headaches
☐Dizziness
☐Walking problems
☐Numbness or tingling
☐Memory loss
☐

Endocrine
☐Thyroid problems
☐Heat or cold intolerance
☐Diabetes

Hematologic
☐Anemia
☐Swollen lymph nodes
☐Leukemia
☐Lymphoma
☐Bleeding problems

Psychiatric
☐Depression
☐Anxious
☐Phobias
☐OCD behaviors
☐Panic attacks

Others
_____

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