



**PATIENT HEALTH HISTORY FORM
FOR VENOUS CLOSURE PROCEDURE**

First Name _____ Last Name _____ MI _____

Social Security# _____ Birth Date _____ Age _____ Gender _____

Marital Status _____ Height _____ Weight _____

Address _____

City _____ State _____ ZipCode _____

Home Phone _____ Work Phone _____

Cell Phone _____

Employer _____ Occupation _____

EmployerAddress _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

Primary Care Information

Primary Care Physician _____ Email _____

Fax Number _____

Please answer all the following questions, trying not to leave any blank.

Due to insurance industry's need to fully understand your medical needs it is necessary to complete as much of this form as necessary. This will also assist our office in assessing your particular needs for proper medical care.



Past Medical History

1) Have you ever been in the hospital as a patient? Yes No
if yes, specify when and for what reason: _____

2) Have you ever had surgery of any kind? Yes No
if yes, specify when and what type of surgery: _____

VEIN HISTORY

Please check if you have:

Small Red "Spider" Veins
Purple Veins
Purple Vein Networks
Flat Bluish Green Veins
Bulging Veins

Skin Discoloration below your knee
Ankle Sores
Vaginal Veins
Abdominal Veins
Diagnosis of vein disease

1) Which leg is the most bothersome to you? Right Left Equal
2) Have you ever had your veins evaluated before? Yes No
If so, what doctor and when? _____

Did this doctor perform any tests on your veins? (i.e. Ultra sound)

3) Do you wear support hose prescribed by a doctor? Yes No
If yes, what type and do they provide relief? Yes No
4) Do you wear light support hose? (i.e. Sheer Energy) Yes No
If so, do they provide relief? Yes No
5) Have you ever had any vein surgery? (Stripping or sclero) Yes No
If yes, what leg? Right Left
6) Have you ever had vein injections? Yes No
If yes, what leg? Right Left
7) Have you ever had any blood clots? Yes No
If yes, what leg? Right Left
8) Have you ever had phlebitis? Yes No
If yes, what leg? Right Left

9) Do you experience any of the following symptoms?

Aching/pain in your legs Yes No Heaviness Yes No
Tiredness/Fatigue Yes No Itching/Burning Yes No



Swollen Ankles Yes No
 Restless Legs Yes No

Leg Cramps Yes No
 Throbbing Yes No

Any other symptoms? _____

- 10) How long have you experienced these symptoms? Month: _____ Years: _____
 11) Does walking help the discomfort? Yes No
 12) Do you stand much at work? Yes No How Long? _____
 Do you stand much at home? Yes No How Long? _____
 13) How do you relieve the discomfort in your legs? Elevate Walk

CURRENT MEDICAL HISTORY

14) Do you have?

	Yes	No	Medications		Yes	No	Medications
Heart Disease				Pacemaker			
Lung Disease				Anemia			
Hepatitis				Arthritis			
Leg Ulcer				Diabetes			
Asthma				Thyroid			
High Blood Pressure							

15) Are you presently under the care of a physician? Yes No If yes, please indicate who an for what illness or purpose: _____

16) Please list all current medications (prescription & non-prescription)

Medication	Dosage	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take blood thinning medications?

Yes No if yes, list _____

Do you take birth control pills or hormones?

Yes No if yes, list _____



17) Do you have any allergies? (i.e. medication, food, pollen) _____

Describe how they affect you? (i.e. hives, rash, shortness of breath) _____

Are you allergic to shrimp/shellfish/or any form of iodine, IVP dye? _____

FAMILY HISTORY

It is important for us to know your family medical history. Please include if any family member has experienced varicose veins, spider veins, leg ulcers, congestive heart failure, and coronary artery disease or had bypass surgery.

Mother (Living) (deceased) Age: ____ Ailments: _____

Father (Living) (deceased) Age: ____ Ailments: _____

Brother(s) Age: ____ Ailments: _____

Sister(s) Age: ____ Ailments: _____

Children Age: ____ Ailments: _____

SOCIAL HISTORY

What is your profession? _____

Do you smoke? If yes, how much? _____

Do you drink alcohol? If yes, how much? _____

WOMEN ONLY: Child Bearing History

1) Do you think you are presently pregnant? Yes No

2) How many times have you been pregnant? Yes No

3) Do you intend to have any more children? Yes No

4) Are you currently breast-feeding? Yes No