Vein Care Specialists
Patient Health History Form
To be completed by the patient.

First Name: _____MI: _____Last Name:_____

I prefer to be called: _____

Date of Birth: _____ Age: _____

Primary Care Physician Name: _____

Do you want us to send a report of our findings to him/her? ☐ Yes ☐ No

How did you hear about Vein Care Specialists? Check all that apply.

☐ Referred by Primary Care Physician ☐ Friend or co-worker

☐ Newspaper ad or article ☐ Magazine ad or article

☐ Other (please specify): _____

Current Occupation: _____

# of hours per workday you are required to stand: _____hours

If you are retired, what kind of work did you do before you retired? _____

History of Present Venous Condition (Check one.)

☐ This is a new condition

☐ This is a chronic condition. How long has this been bothering you? _____

Leg Signs and Symptoms: please check all that you have experienced in the past six months.

☐ Enlarged veins that are visible on your skin ☐ Itching or Burning

☐ Fatigue/Heavy Feeling ☐ Swelling of leg or ankle

☐ Throbbing or Cramping ☐ Leg ulcer / sores

☐ Pain or tenderness. Please rate the severity of your pain by circling the number below.

1 (very mild) – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (severe)

What have you tried to relieve your pain? _____

_____

In the past year have you: (please check all that apply)

☐ Tried support stockings for at least 3 months to relieve your leg vein condition without success?

☐ Had to take pain medication because of your vein condition?

☐ Needed to take time off work because of your leg condition?

☐ Needed to limit your activities and/or lifestyle because of your leg condition?

Physician Review:

_____	_____	_____	_____	_____
Initial / Date	Initial / Date	Initial / Date	Initial / Date	Initial / Date

Have you ever had any of the following conditions to your legs? Check all that apply and identify which leg was affected.

Condition	Affected Leg(s)		
☐ Injury that required surgery or casting	Right	Left	Both
☐ Deep vein thrombosis (DVT) / blood clot	Right	Left	Both
☐ Phlebitis (inflammation of leg veins)	Right	Left	Both
☐ Venous stasis ulcer (leg sores due to poor circulation)	Right	Left	Both
☐ Bleeding from a varicose vein	Right	Left	Both
☐ Vein stripping	Right	Left	Both
☐ Sclerotherapy (vein injections)	Right	Left	Both

If you answered "yes" to any of these conditions, please provide details, treatment provided and the year it occurred in the space below.

Past and Current Medical History

List any medications you take (drug name, dosage, frequency)

Include prescription, over-the-counter, herbal or dietary supplements.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies you have (include medication, food, environmental, tape, Latex, other)

_____ _____

_____ _____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Do you have any blood borne diseases (Hepatitis, AIDS, other)? ☐ Yes ☐ No

Please list any surgeries you have had starting with the most recent. Please include the year.

_____

_____

_____

_____

_____

Physician Review:

_____	_____	_____	_____	_____
Initial / Date	Initial / Date	Initial / Date	Initial / Date	Initial / Date

Review of Systems

Do you have or have you experienced any of the following conditions? Please circle yes or no for each line.

Circulatory Problems

Yes No Chest Pain
Yes No Congestive Heart Failure
Yes No Irregular Heart Rhythm
Yes No High Blood Pressure
Yes No History of a heart attack
Yes No Other heart problems
Yes No Fainting
Yes No General Fatigue
Yes No Blood Clots
Yes No Bleeding disorder

Respiratory Problems

Yes No Shortness of breath
Yes No Wake up breathless
Yes No Productive cough (sputum or blood)
Yes No Pain with breathing
Yes No Asthma
Yes No Emphysema
Yes No Smoker: _____ packs per day
Yes No Use of smokeless tobacco / chew

Gastrointestinal Problems

Yes No Change in bowel habits
Yes No Nausea or vomiting
Yes No Abdominal pain
Yes No Ulcers
Yes No Inflammatory Bowel Disease
Yes No Liver Disease

Diabetes

Yes No Insulin dependent
Yes No Oral medications
Yes No Controlled with diet and exercise

Genitourinary

Yes No Kidney disease
Yes No Prostate disorder
Yes No Incontinence
Yes No Painful urination
Yes No Frequent urination

Musculoskeletal

Yes No Changes in walking ability
Yes No Change in strength
Yes No Painful joints
Yes No Arthritis
Yes No Spinal disorder

Neurological

Yes No Loss of memory or movement
Yes No Unexplained numbness
Yes No Tingling

Ear, Nose and Throat

Yes No Change in hearing
Yes No Nasal discharge
Yes No Sore throat

Physician Review:

_____ _____ _____ _____ _____
Initial / Date Initial / Date Initial / Date Initial / Date Initial / Date

Vision Problems

Yes No Vision loss or recent changes

Yes No Double vision

Yes No Excessive tearing

Yes No Glaucoma

Yes No Blindness

Skin

Yes No Rashes or change in skin color

Yes No Sores that won't heal

Yes No Itching

Other Medical Conditions

Yes No Thyroid Disorder

Yes No Cancer: Type__________________

Other

Yes No Anxiety

Yes No Depression

Yes No Recent weight loss or gain (unintentional)

Yes No Recent loss of or increased appetite

Yes No General fatigue

Yes No Alcohol Use

________ alcoholic beverages per week

Yes No Recreational Drug Use

Do any of your blood relatives have a history of: (please check all that apply)

☐ Diabetes ☐ Heart Disease ☐ Cancer

☐ High Blood Pressure ☐ Kidney Disease ☐ Liver Disease

☐ Varicose Veins ☐ Blood Clots ☐ Vein Surgeries

☐ Venous Ulcers (leg sores due to circulatory problems)

I have provided true and accurate information to all of the above questions to the best of my knowledge and ability.

_______________________________________ _______________________________

Patient Signature Date

For Vein Care Specialists Use Only

Physician Comments:

I have reviewed this patient history and review of systems with the patient.

_______________________________________ _______________________________

Physician Signature Date

Physician Review:

________________	________________	________________	________________	________________
Initial / Date	Initial / Date	Initial / Date	Initial / Date	Initial / Date