

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

ALL OF THE FOLLOWING INFORMATION IS ASKED BY INSURANCE COMPANIES CONCERNING MEDICAL HISTORY AND SYMPTOMS.

YOUR SYMPTOMS: **Left Leg** **Right Leg**

_____	_____	Leg pain, often from prolonged sitting or standing
_____	_____	Swollen ankles, often at night
_____	_____	Tired, heavy feeling legs
_____	_____	Varicose Veins
_____	_____	Spider Veins
_____	_____	Tingling, numbness, burning or cramping in legs and feet
_____	_____	Discoloration on the skin
_____	_____	Open sores or ulcers on lower leg
_____	_____	History of vein problems in the family
_____	_____	(Relationship of family member(s) _____)

HOW LONG HAS YOUR VEIN PROBLEM EXISTED? _____

VEIN SIZE AND LOCATION (CHECK ALL THAT APPLY):

LEFT LEG _____ LARGE _____ MEDIUM _____ SPIDER VEINS _____
RIGHT LEG _____ LARGE _____ MEDIUM _____ SPIDER VEINS _____

HAVE YOU EVER HAD YOUR VEINS TREATED BEFORE? _____ NO _____ YES (CHECK ALL THAT APPLY)
STRIPPING: _____ DATE: _____ INJECTIONS: _____ DATE: _____

HAVE YOU WORN MEDICAL COMPRESSION HOSE: _____ OR SUPPORT HOSE: _____
IF YES, HOW LONG HAVE YOU USED THEM? _____

MEDICAL HISTORY (CHECK ALL THAT APPLY)

HIGH BLOOD PRESSURE _____	HEART DISEASE _____
DIABETES _____	HIGH CHOLESTEROL _____
STROKE _____	TOBACCO USE _____
OTHER _____	

MEDICATIONS: (PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING) CHECK IF NONE

NAME	DOSE	FREQUENCY
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____
_____ / _____	_____ / _____	_____

DRUG ALLERGIES: CHECK IF NONE _____

HISTORY OF BLOOD CLOTS IN YOUR VEINS? (CIRCLE ONE) YES NO

DEEP VEINS _____ SURFACE VEINS _____

DATE FORM COMPLETED _____ PATIENT SIGNATURE _____