

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) _____)

Do you have any of the following or have to do any of the following due to your vein problems: _____ elevate feet & legs
_____ massage legs & feet _____ take over the counter pain meds _____ take meds for swelling _____ walk around to relieve problems

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 _____

PATIENT SIGNATURE _____ DATE FORM COMPLETED _____