MEDICAL HISTORY: Please circle correct responses or fill in the blanks where applicable.

Name: ______________________________ **Today's Date:** _____ _____ _____

Date of Birth: ______________ **Age:** _______ **Hgt.:** ____ ft ____ in **Wgt.:**______ lbs

1. When did you first notice enlarged veins? ______________________________

2. Is one leg worse than the other? right left same

3. How do the veins bother you?

sharp pain	yes	no
aches/discomfort	yes	no
congestion/pressure	yes	no
swelling	yes	no
itching	yes	no
appearance	yes	no

4. Have you ever had these problems?

			Dates:
clots in legs (phlebitis)	yes	no	________
deep vein thrombosis	yes	no	________
clots in lungs (embolus)	yes	no	________
leg/ankle ulcers	yes	no	________
vein x-ray (venogram)	yes	no	________
taken blood thinners	yes	no	________

5. Describe any experience with support stockings: ______________________________

____

6. List all operations, hospitalizations, or serious illnesses: **Dates:**

______________________________ ________

______________________________ ________

______________________________ ________

7. Have you had previous injection therapy of your veins? yes no

Dates: ______________ **Results:** ______________________________

8. Do you or have you ever had the following?

			Dates:
Diabetes	yes	no	________
Thyroid disease	yes	no	________
High blood pressure	yes	no	________
Heart disease or heart attack	yes	no	________
Jaundice or Hepatitis	yes	no	________
Cancer	yes	no	________
Weight change of 10 lbs in last 6 mo.	yes	no	________
Easy bruising or free bleeding	yes	no	________
Leg Pain caused by walking	yes	no	________
Major injury or surgery in your legs	yes	no	________

9. Number of pregnancies: __________ **Number of deliveries:**__________ **Dates:**__________

10. Are you pregnant? yes no **Are you breast feeding:** yes no

11. List hormones you have taken (including birth control pills) and dates of usage: __________

____

12. List current medications and dosages: ______________________________

____

____

13. List all allergies: ______________________________

14. Have you ever smoked? yes no **How much?** __________ **How long?** __________

Are you still smoking? yes no **When did you quit?** __________

15. Family members with vein problems: ______________________________

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