PONTE VEDRA Vein INSTITUTE

Medical History Form

Name: _____

Date: _____ /_____ /_____ **Age:** _____ **Smoke**(Years): _____

☐ High Blood Pressure	☐ Heart Disease	☐ Hepatitis	**Drug Allergies**
☐ Mitral Valve Prolapse	☐ Bleeding Disorder	☐ Stroke	_____
☐ Open Heart Surgery	☐ Pulmonary Embolus	☐ Diabetes	_____
☐ Superficial Phlebitis	☐ Deep Venous Thrombosis	☐ Seizures	_____

Are you pregnant or nursing? _____Y _____N _____N/A

Family Physician: _____Phone number: (_____)_____-_____

Surgical History (List all surgeries and approximate year)

_____

_____

_____

List all medications you are currently taking _____

_____

_____

_____

Symptoms:

☐ Aching or Throbbing	☐ Leg Pain	☐ Red/warm areas	☐ Spider Veins
☐ Tired or heavy legs	☐ Ankle/leg Swelling	☐ Restless Legs	☐ Skin changes
☐ Night Cramps	☐ Ulcers or ulceration	☐ Burning pain in legs	☐ Hard lumps
☐ Itching	☐ Tenderness	☐ Varicose veins (bulging)	☐ Other _____

Personal History of Varicose Veins or Spider Veins:

_____ **List number of years**

Y N Related to Pregnancy?
Y N Related to Accident Trauma?
Y N Are you developing new veins?
Y N Are your present veins getting bigger?
Y N Do you smoke?
Y N Does your discomfort/leg pain interfere with your activities of living?

Are your symptoms worse with:

Y N Prolonged standing?
Y N Prolonged sitting?
Y N Menstrual cycle?

Are your symptoms relieved with?

Y N Rest/Elevation of leg (s)?

Family History of Varicose Veins or Spider Veins:

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Uncle ☐ Aunt ☐ None

Patient Signature_____**Date:** _____ /_____ /_____

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Previous Treatment History:

Y N Ligation/Stripping Surgery If so, which leg? _____ When? _____
Y N Injection Treatments If so, which leg? _____ When? _____
Y N Laser Therapy If so, which leg? _____ When? _____
Y N Other_____

Previous conservative treatment you have tried:

Y N Do you take pain medications (Advil Tylenol Aspirin) for your leg pain/veins?
Y N Have you worn compression hose or active support hose for your current problem for 6 months or longer?
When? _____
Y N Did they help your symptoms (leg pain/swelling)? Totally Partially
Y N Have you been taking over the counter anti-inflammatory medications for 6 months or longer for leg pain?
Y N Do you routinely rest and elevate your legs to help relieve leg pain and/or swelling?
Y N If yes, have you done so for 6 months or longer?
Y N Has your varicose vein problem caused a physical impairment due to pain, swelling, throbbing, tired feelings, etc.?

What specifically do you feel you can no longer do because of your varicose veins?

_____

_____

_____

Y N Have you discussed your varicose vein problem with your primary care doctor or any other doctor?
If so, what did the doctor recommend that you do?

_____

_____

_____

What have you tried on your own to help alleviate your symptoms, beyond what you have already indicated?

_____

_____

_____

How did you hear about us?

☐ Friend ☐ Newspaper ☐ Doctor ☐ Other_____
☐ Magazine ☐ Internet ☐ Relative

Patient Signature_____ Date: _____ /_____ /_____

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