Total Vein Care Patient History Form

Name_____ Date:_____

Date of Birth: _____ Age:_____ Sex: Female Male

Email Address: _____

Directions: Please answer the following questions. Provide estimates for the date of occurrence.

Did a physician refer you? □ Yes □ No If so, whom?_____

How did you hear about us?_____

Who is your Primary Care Physician?_____

Who is your OB/GYN?_____

Venous Health History

1. Have you ever had vein stripping surgery? □ Yes □ No
   If yes, which leg? □ Right □ Left □ Both
   When?_____

2. Have you ever had sclerotherapy? □ Yes □ No
   If yes, which leg ? □ Right □ Left □ Both
   Where?_____
3. Have you ever had phlebitis (superficial blood clots)? □ Yes □ No
   If yes, which leg? □ Right □ Left □ Both
   When?_____
4. Have you ever had a Deep Vein Thrombosis (DVT)? □ Yes □ No
   If yes, which leg? □ Right □ Left □ Both
   When?_____

5. Do you have a history of any blood clotting disorders?_____

6. Do you experience any of the following in your legs?

Aching/Pain?	□ Yes □ No	Swollen Ankles?	□ Yes □ No
Heaviness?	□ Yes □ No	Throbbing?	□ Yes □ No
Tiredness/Fatigue?	□ Yes □ No	Leg Cramps?	□ Yes □ No
Itching/Burning?	□ Yes □ No	Other:_____	

7. Have your veins gotten worse in the recent months? □ Yes □ No
   Describe:_____

8. Do you wear prescription compression hose? □ Yes □ No

9. Do you ever elevate your legs to relieve discomfort? □ Yes □ No

(Please flip over and fill out back of page.)

10. Do you take any medication for pain in your legs? □ Yes □ No
If yes, what do you take and how often?_____

11. Are you on any blood thinners?
Coumadin Plavix Persantine Aspirin Other:_____

12. Do you have a history of migraine headaches? □ Yes □ No

Family History

1. Does anyone in your family have varicose veins or spider veins? □Yes □ No
Mother Grandmother Father Grandfather Sister Brother Children

Medical History:

1. Please list any medical conditions:_____
_____
_____

2. Please list any surgical history:_____
_____
_____

3. What medications are you allergic to?_____

4. Please list your current medications (list dosages if you know them)_____
_____
_____

5. Are you taking any medications that end with -cycline? □ Yes □ No

6. Are you currently Pregnant? □ Yes □ No Breastfeeding? □ Yes □ No

7. How many children do you have?_____

8. Do you smoke? □ Yes □ No If so, how much?_____

9. Do you have a history of Patent Foramen Ovale? □ Yes □ No
(Defect in the wall between the two upper chambers of the heart.)

10. What type of work do you do?_____