## MINNESOTA VEIN CENTER

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## Venous Medical History

Today's Date			
me Date of Birth			
Referring PhysicianPhone			
Reason you are seeking treatment for your legs (circle): Medical Cosmetic			
Which leg is bothering you the most? (Circle): Right Left Both			
Have you ever had an evaluation or treatment for your veins? (Circle): Yes No			
If Yes, Please explain including when this happened and if an ultrasound was done:			
Have you are Communication Of calcings Dresquib ad by a Doctorii (Circle) Very New			
Have you ever worn Compression Stockings Prescribed by a Doctor? (Circle): Yes No			
If Yes, How long?			
Did they provide relief of your symptoms? (Circle): Yes No Are you still wearing them? (Circle) Yes No			
If no, why did you stop wearing them?			
What kind of Leg Symptoms are you having? (Circle any that apply) Pain Swelling Burning Itching Throbbin			
Heaviness Cramping Fatigue Restless Legs Swollen Ankles Aching Tingling Bleeding Phlebitis			
Have your symptoms increased in recent months? (Circle): Yes No			
Do they interfere with your daily activities or walking? (Circle): Yes No If Yes, Please explain			
Do your symptoms keep you awake at night? (Circle): Yes No If Yes, Please explain			
What have you tried to relieve your leg symptoms? (Circle all that apply)			
Leg Elevation Support Hose Analgesics (Tylenol, Advil, Aleve) Prescription Pain Medication			
Exercise: What type of exercise? Other			

Past Medical History:	
(Circle all that apply): Diabetes- Oral medication Insulin T	hyroid Disease Asthma HIV Liver Disease
Heart Disease- Type? Arthritis Osteoporosis Lu	ung Disease High Blood Pressure Heart Murmur Peptic Ulcer
Cancer Bleeding Disorder Kidney Disease High Cholester	ol Depression Stroke Seizures Vascular Disease
Surgical History or Serious Illness:	
TypeYearTyp	eYear
TypeYearTyp	eYear
Allergies:	
Are you allergic to any medication, latex, surgical tape or dye	? (Circle) Yes No
Please list	
Medications:	
Please list any Prescription Medications, Herbal Products or	over the counter medications you take.
NameDoseHow m	any per day
NameDoseHow m	any per day
NameDoseHow m	any per day
NameBoseHow m	any per day
Do You Take Blood thinning Medication? (Coumadin, Warfar	in, Plavix, Aspirin) (Circle) Yes No
If yes, what do you take and how often?	
Prescribing Physician:	
Social History:	
What is your Occupation?	
What is your marital status? (Circle) Married Divorced	Widowed Single
Do you currently smoke? (Circle) Yes No Never If	Yes, How Much? per day.
If No, What year did you quit? How many y	rears did you smoke?
Do you Drink Alcohol? (Circle) Yes No If Yes, How	many per week?
Family History: Circle any condition on either side of your f	amily
Allergies Heart Disease Kidney Disease Arthritis	Bone Disease Blood Disease Cancer Diabetes
Thyroid disease Mental illness Bleeding Tendencies	Other:

Please explain:

## Review of symptoms

Please circle any and all that apply:

General Weight Loss Weight Gain Fever Fatigue	Eyes Pain Discharge Light Sensitivity Blurred Vision	ENT Sore Throat Hoarseness Ears Ringing Nose Bleeds	Respiratory Wheezing Cough Shortness of Breath
<u>Cardiovascular</u> Chest Pain Feet Swelling Palpitations	Gastrointestinal Nausea Vomiting Diarrhea Blood in Stool	Genitourinary Hesitancy Flank Pain Painful Urination Blood in Urine	Neurological Confusion Numbness Slurred Speech Seizures
Musculoskeletal Joint Swelling Joint Redness Joint Pain Gait Problems Leg Pain with Walking	Skin/Breast Rash Itching Sores Abscess Discharge	Endocrine Excess Sweat Excess Thirst Excess Hot Excess Cold	Hematology/Lymphatic Bleeding Tendencies Lymph Node Swelling Easy Bruising
Psychological Anxiety Depression Severe Stress Claustrophobia Panic Disorder			
Explanations or Other:			
Patient/ Guardian Signature			Date
Reviewed by:			