MINNESOTA VEIN CENTER
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Venous Medical History

Today's Date_____

Name_____ Date of Birth_____

Referring Physician_____Phone_____

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 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 Throbbing

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 Thyroid Disease Asthma HIV Liver Disease

Heart Disease- Type? _____ Arthritis Osteoporosis Lung Disease High Blood Pressure Heart Murmur Peptic Ulcer

Cancer Bleeding Disorder Kidney Disease High Cholesterol Depression Stroke Seizures Vascular Disease

Surgical History or Serious Illness:

Type_____Year_____Type_____Year_____

Type_____Year_____Type_____Year_____

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.

Name _____Dose _____How many per day _____

Name _____Dose _____How many per day _____

Name _____Dose _____How many per day _____

Name _____Dose _____How many per day _____

Do You Take Blood thinning Medication? (Coumadin, Warfarin, 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 years 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 family

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

Cardiovascular
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: _____