Vein Care Specialists
Patient Health History Form

First Name: ______________________**MI:**______**Last Name:**___________________________________
Date of Birth: ____

History of Present Venous Condition (Circle one):

This is a new condition: N Y (if **no**, how long has it been bothering you? _____________)

How many hours **per day** are you on your feet?____

Do you have:	No	Yes
Enlarged veins that are visible on your skin	N	Y
Achiness	N	Y
Throbbing	N	Y
Cramping	N	Y
Itching	N	Y
Heaviness	N	Y
Skin Discoloration	N	Y

Please rate your **Pain Level**: 1(very low)-2- 3-4-5-6-7-8-9-10 (very high)

Do you use pain medication for your leg pain/discomfort? N Y

(If yes, specify type of medication: ____)

Do you use/have you used compression stocking? N Y

(If yes, specify type of stocking ________________how long ____________weeks/months/year)

Due to symptoms above, are you limited in any of the following activities?

	No	Yes
Work	N	Y
Housework (cooking, cleaning, etc.)	N	Y
Walking	N	Y
Shopping	N	Y
Sitting	N	Y
Kneeling	N	Y
Sports or hobbies	N	Y
Social Limitations	N	Y

Have you ever had any of the following on your leg(s)?

	Affected Leg(s)		
Injury that required surgery or casting	Right	Left	Both
Phlebitis (inflammation of leg vein)	Right	Left	Both
Bleeding from a varicose vein	Right	Left	Both
Vein procedure	Right	Left	Both

If you circle any of the above conditions, please provide details, treatment provided and the year it occurred: ____
____

Do any of your blood relatives have a history of: (please mark all that applies)

	No	**Yes**	**Relationship**
Vein surgeries	N	Y	___________
Blood clot	N	Y	___________
Varicose veins	N	Y	___________
Venous ulcers (leg sores)	N	Y	___________

What are your expectations for today's visit?

1. Evaluate leg pain and /or swelling
2. To learn more about my vein problem
3. To learn about surgical options for varicose veins
4. To learn about cosmetic options for spider veins
5. Other:____

REVIEW OF SYSTEMS (Circle all that apply)

SYSTEMIC	Yes
Fatigue/Weakness	Y
Recent change in weight	Y
Fever	Y
Chills	Y
Recurrent Infections	Y
Night sweats	Y

EYES/EARS/NOSE/THROAT	
Eye pain	Y
Blurred vision	Y
Sore throat	Y
Sinus pain	Y
Hearing problem	Y
Nosebleeds	Y

NEUROLOGICAL	
Dizziness	Y
Fainting	Y
Numbness	Y
Tremors	Y
Tingling	Y
Convulsions	Y
Headache	Y
Memory lapses or loss	Y

RESPIRATORY	
Cough	Y
Wheezing	Y
Shortness of breath	Y
Blood in sputum	Y

CARDIOVASCULAR	
Palpitations	Y
Leg pain with exertion	Y
Chest pain	Y
Ankle swelling	Y
High blood pressure	Y

GENITOURINARY	
Burning with urination	Y
Difficulty starting stream	Y
Urinating at night	Y
Urinary incontinence	Y
Slow urinary stream	Y
Urinary frequency	Y
Blood in the urine	Y

GASTROINTESTINAL	Yes
Abdominal Pain	Y
Constipation	Y
Diarrhea	Y
Nausea	Y
Vomiting	Y
Decrease in appetite	Y
Difficulty swallowing	Y
Heartburn	Y
Belching	Y
Bloating	Y
Change in stools	Y
Rectal pain	Y

HEMATOLOGICAL	
Easy bruising	Y
Bleeding problem	Y

MUSCULOSKELETAL	
Neck pain	Y
Diffuse joint pain	Y
Back pain	Y

SKIN	
Rashes	Y
Itching	Y
Recurrent skin infections	Y

ENDOCRINE	
Swollen glands in the neck	Y
Groin lymph node swelling	Y
Excessive thirst	Y
Temperature intolerance	Y

PSYCHIATRIC	
Depression	Y
Anxiety	Y
Feeling Nervous	Y
Difficulty falling asleep	Y

BREAST	
Breast lump	Y
Breast pain	Y
Breast reddening	Y
Nipple discharge	Y
Nipple inverted	Y
Asymmetrical	Y
Breast swelling	Y

Print Name: ____