Print Name _____ DATE_____ Patient # _____

FIVE STAR VEIN INSTITUTE

MEDICAL HISTORY

AGE_____ SEX_____ OCCUPATION [including Housewife] _____

HOW DID YOU HEAR ABOUT US?_____FAMILYDOCTOR_____

REASON FOR COMING TO THE OFFICE _____

WHAT ARE YOUR SYMPTOMS?—PLEASE CIRCLE ALL THAT APPLY. R and L STAND FOR Right and Left Legs

PAIN	R L	SWELLING	R L	SKIN CHANGES	R L
ACHING	R L	CRAMPING-DAY	R L	WOUNDS OR SORES	R L
HEAVINESS	R L	CRAMPING-NIGHT	R L	BRUISING	R L
TIGHTNESS	R L	FATIGUE	R L	BLEEDING	R L
BURNING	R L	ITCHING	R L	UGLY, UNSIGHTLY VEINS	R L
RESTLESS LEGS	R L	PELVIC PAIN			

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

ARE THESE SYMPTOMS OR PROBLEMS GETTING WORSE? _____

ARE THEY ADVERSELY AFFECTING YOUR QUALITY OF LIFE? [PLEASE CIRCLE]-- NO
YES- MILDLY MODERATELY SEVERELY

THE ABOVE SYMPTOMS OCCUR OR ARE WORSE WITH:
SITTING STANDING EXERCISE [CIRCLE ANY THAT APPLY]

PREVIOUS CONSERVATIVE TREATMENT FOR VARICOSE VEINS [INCLUDING STOCKINGS, LEG ELEVATION]
_____

HOW LONG HAVE YOU WORN SUPPORT STOCKINGS?_____

IS THERE A FAMILY HISTORY OF VARICOSE VEINS? _____

MEDICATION HISTORY

ALLERGIES:_____

MEDICATIONS:_____

_____

Name _____ Date _____

PAST VENOUS HISTORY

PREVIOUS INJECTIONS FOR VARICOSE VEINS [WHAT, WHEN, WHERE] _____
_____

PREVIOUS SURGERY FOR VARICOSE VEINS [WHAT, WHEN, WHERE] _____
_____

WERE ANY OF THE ABOVE TREATMENTS SUCCESSFUL? [PLEASE EXPLAIN] _____
_____
_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING PHLEBITIS? _____
IF YES, THEN WHEN AND WHERE ON YOUR LEGS? _____
_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING BLOOD CLOTS IN THE LEGS? _____
IF YES, THEN WHEN AND WHERE ON YOUR BODY _____
WHAT TREATMENT WAS GIVEN FOR THIS? _____
ARE THERE ANY RESIDUAL EFFECTS FROM THIS? _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING A BLOOD CLOT TO THE LUNGS? _____
IF YES, WHEN AND WHAT TREATMENT WAS GIVEN_____
_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING A BLOOD CLOTTING DISORDER? _____

HAVE YOU EVER HAD PROBLEMS WITH HEMORROIDS?_____

HAVE YOU EVER USED IV DRUGS? [DESCRIBE WHEN, WHAT, HOW LONG] _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING AIDS OR HEPATITIS? _____
_____

PAST MEDICAL HISTORY

HAVE YOU USED ALCOHOL? _____
IF YES, THEN HOW MUCH AND WHEN: _____

DO YOU GET MUCH EXERCISE? _____
DESCRIBE YOUR EXERCISE PATTERN _____

HAVE YOU USED TOBACCO IN ANY FORM? _____
IF YES, THEN HOW OFTEN AND WHEN: _____

Name _____ Date _____

PREVIOUS ACCIDENTS AND TREATMENT [INCLUDE DATES]:

_____
_____
_____

PREVIOUS OPERATIONS OR HOSPITALIZATIONS [WHEN AND FOR WHAT REASON]:

_____
_____
_____
_____
_____
_____

# of pregnancies_____
# of births_____

REVIEW OF SYSTEMS

UNDER EACH HEADING PLEASE DESCRIBE ANY CONDITIONS THAT PERTAIN TO YOU. THE CONDITIONS LISTED ARE ONLY EXAMPLES. PLEASE **DESCRIBE** ANY OTHERS YOU MAY HAVE:

GENERAL/CONSTITUTIONAL- for example high blood pressure, weight loss or gain, fever, fatigue, high cholesterol, high lipids, or any other generalized problems

SKIN-describe any conditions past or present

_____

EYES-describe any conditions past or present including temporary blindness_____

EARS, NOSE, MOUTH, THROAT, SINUS-describe any conditions past or present_____
_____

NEUROLOGIC-describe any conditions past or present including neuropathy, stroke, loss of speech or any other
_____
_____

GASTROINTESTINAL-describe any history problems with stomach, liver, etc._____
_____

Name _____ Date _____

CARDIAC-describe any type of heart trouble_____
_____

RESPIRATORY-describe any type of respiratory trouble past or present_____
_____

KIDNEY OR BLADDER-describe any problems_____
_____

MUSCULOSKELETAL-describe any problems_____
_____

MENTAL-describe any problems including anxiety, depression, etc._____
_____

ENDOCRINE-describe any diabetes, thyroid or adrenal problem, etc._____
_____

HEMATOLOGIC-describe any bleeding or clotting problems_____
_____

IMMUNOLOGIC-describe immunologic problems such as lupus, rheumatoid arthritis, etc_____
_____

ARTERIAL VASCULAR-describe any problems including pain on walking 1-3 blocks, etc_____
_____

OB-GYN-

Date of last period_____
Last pelvic exam_____
Any breast or female problems including pain, spotting, lumps, discharge_____
_____

OTHER MEDICAL PROBLEMS NOT INCLUDED IN THE ABOVE LIST [for example high cholesterol, high triglycerides]—please describe in the space below any other medical problems

_____
_____
_____
_____
_____
_____
_____
_____