Advanced VASCULAR & VEIN CENTER

Name_____**Date**_____

Medical History

What brought you in today? _____

(Circle appropriate answers)

Diabetes Y/N

High blood pressure Y/N

Heart failure Y/N

Smoker Never/Current/Quit

Do you take blood thinners? Y/N If Yes, please list_____

Have you ever had a blood clot in your legs or lungs? Y/N

Do you have a family history of blood clots? Y/N

Do you have leg swelling? Y/N

Do you have visible varicose veins or spider veins? Y/N

Do you have inflammatory bowel disease? Y/N

Do you have emphysema or COPD? Y/N

Have you had more than three days of continuous bed rest due to injury or illness in the past month? Y/N

Have you had a pelvic fracture or a plaster leg cast in the last month? Y/N

Have you had a stroke, heart attack, or heart failure? Y/N

Have you had a major surgery lasting over an hour in the last month? Y/N

Do you have or have you had a malignant disease (cancer)? Y/N

Do you weigh over 250 pounds? Y/N

AGE (Circle) Under 40 40-59 60-69 Over 70

WOMEN only

Do you use birth control pills or estrogen replacement therapy? Y/N

Are you pregnant or have you had a baby in the last month? Y/N