VEIN centers for excellence™
No one knows legs like we do!

Patient Medical History

Patient Name: ______________________________ Date: ______________

Please check if you have even been diagnosed with or treated for the following:

○ High Blood Pressure	○ Heart Disease	○ Hepatitis
○ Diabetes	○ Asthma	○ Phlebitis/Blood Clots- Superficial or Deep
○ Arthritis	○ HIV/AIDS	○ Lung Disease/COPD
○ Pulmonary Embolus	○ Other ______________	

Have you ever had surgery? ○ Yes ○ No
If yes, what type of surgery and when? ______________________________
____

Are you currently taking any medications? ○ Yes ○ No
If yes, please list ______________________________
____

Are your allergic to any medications/foods? ○ Yes ○ No
If yes, please list ______________________________

Do you take any blood-thinning medication? ○ Yes ○ No

Do you smoke? ○ Yes ○ No
If yes, how many packs per day? __________

Is there a family history of blood clots? ○ Yes ○ No
If yes, please explain ______________________________

Have you ever had a prior leg injury or fracture? ○ Yes ○ No
If yes, please explain ______________________________

Family History of Varicose or Spider Veins (please check):
○ Mother ○ Father ○ Sister ○ Brother ○ Grandmother ○ Grandfather ○ Uncle ○ Aunt ○ None

Females Only:
Are you pregnant or trying to become pregnant? ○ Yes ○ No
Are you currently breast-feeding? ○ Yes ○ No
Are you taking hormones or birth control pills? ○ Yes ○ No
If yes, for how many years? __________
Were your veins made worse with pregnancy? ○ Yes ○ No
Total number of pregnancies you have had: _____ How many children? _____ # of miscarriages? _____

Family physician's name, address, and phone number: ______________________________
____

Whom may we thank for referring you to our office? ______________________________

Patient Signature ______________________________ Date __________

Physician Signature ______________________________ Date __________