

Patient Medical History

Patient Name: _____ Date: _____

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

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Phlebitis/Blood Clots- Superficial or Deep
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Lung Disease/COPD
<input type="checkbox"/> Pulmonary Embolus	<input type="checkbox"/> 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 you 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 _____