1114 Charlevoix Ave.
Petoskey, MI 49770

Venous Medical History

Name:____ DOB:___________________ Age:__________ Date:_____________

Home phone:__________________ Work phone:__________________ Cell phone:________________________

Who Referred you to us today? Self____or Physicians name:___________________________

How did you hear about us? ☐ **Friend** ☐ **Newspaper** ☐ **TV** ☐ **Web**

☐ **Other**____

Patient's Occupation: ____Primary Physician__________________________________

Reason you are seeking treatment for your veins: ____

____

How long have you had the veins you are concerned about?____

Please circle any symptoms that you have in your legs:

Swell **Ache** **Red and Inflamed** **Bulging Veins** **Cramp** **Burn/Itch** **Restless Legs**

Do your symptoms negatively impact your daily activities? ☐ **Yes** ☐ **No**

Do your symptoms negatively impact your ability to perform your occupation? ☐ **Yes** ☐ **No**

Are your veins getting worse? ☐ **Yes** ☐ **No** Is one leg worse than the other? **R> L** or **L>R** or **L=R**

Have you ever had treatment of your veins? ☐ **Yes** ☐ **No** If yes, Where? ____

And what type of treatment? ____

Have you ever worn compression hose? ☐ **Yes** ☐ **No** If Yes, How long?________ Did they help? ☐ **Yes** ☐ **No**

Do you have children? ☐ **Yes** ☐ **No** If yes, How many and what are their ages?______________________________

____

For female patients: Did your veins develop during a pregnancy? ☐ **Yes** ☐ **No**
Did you experience labial varicosities during your pregnancies? ☐ **Yes** ☐ **No**
Do you suffer from hemorrhoids? ☐ **Yes** ☐ **No**

Has anyone in your family had a history of varicose veins? ☐ **Yes** ☐ **No** If Yes, Who?___________________________

Have you ever been treated for a blood clot in your legs? ☐ **Yes** ☐ **No** If Yes, Which leg? **L** **R**

Have you ever had an ulcer on your legs? ☐ **Yes** ☐ **No** If Yes, Which leg? **L** **R**

Do you have any congenital heart conditions? ☐ **Yes** ☐ **No** If yes, please explain: ________________________________

Please circle any of the following medical problems you have:

High Blood Pressure **Heart Disease** **Lung Disease** **Liver Disease**

Peripheral Vascular Disease **Thrombophilia** **Cancer** **Diabetes**

Please list any pertinent medical conditions you have that are not listed above:

____

____

Medications you are currently taking: ____

____

Are you currently taking any blood thinners or Aspirin? ☐ **Yes** ☐ **No** If Yes, Why? ________________________

Please list any allergies you have: ____

____

Please list any previous surgeries and dates: ____________________________________

____

Have you ever smoked? ☐ **Yes** ☐ **No** If yes, for how long?__________________________________

If you quit smoking, how long has it been since you quit? _____________________________

Remainder to be filled out by Technicians

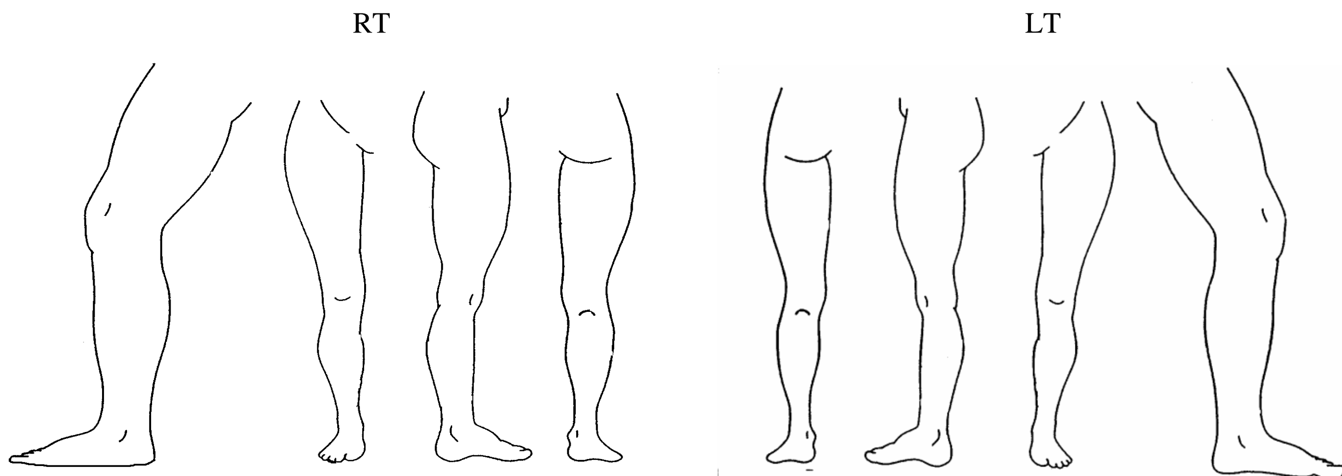
BP: _______/________ **mmHg** **Pulses: DP** __________ **PT**________

☐ **Capillary Refill** ☐ **Muscle Strength** ☐ **Lipodermatosclerosis** ☐ **Ulcers** ☐ **Dermatitis**

Physical Findings:____

Additional work-up required: ____

RT LT



Thigh _____ Calf _____ Ankle _____ Thigh _____ Calf _____ Ankle _____

Interviewer's signature: ____ Date: ___________

REVISED 8-10-2009