

Alabama Vascular and Vein Patient Health History Form

Have you ever had any of the following:	Right	Left	Both	Neither	If so, When?
An injury to either of your legs that required an operation or casting?					
A deep vein thrombosis (D.V.T.). Also known as a blood clot in your leg?					
Phlebitis?					
A Venous Stasis Ulcer?					
Hemorrhage from a Varicose Vein?					
Sclerotherapy?					
Vein stripping?					

Please answer the following very carefully, as it will help your insurance company decide if your vein problems are a covered benefit. In the last six months have you

. . .tried support stocking to relieve your vein problems without success?	Yes	No
. . .had to take pain medicine because of your vein problems?	Yes	No

. . .had to take time off work because of your vein problems?	Yes	No
. . .had to limit your activities and lifestyle because of your vein problems?	Yes	No

Please indicate if you have any of the following conditions by circling Yes or No:

Diabetes	Yes	No
Heart Disease	Yes	No
Lung Disease	Yes	No
Hypertension	Yes	No
Arthritis	Yes	No
Cancer	Yes	No

Seizures	Yes	No
Renal Failure	Yes	No
Hepatitis	Yes	No
HIV Infection	Yes	No
Fainting	Yes	No
Tobacco Use	Yes	No

Please indicate (by circling Yes or No) if you currently (or recently) were on any of the following:

Coumadin	Yes	No
Plavix	Yes	No
Daily Aspirin	Yes	No

Topical skin medications	Yes	No
Antibiotics	Yes	No
Steroids	Yes	No

For Women Only: Please indicate if Yes or No if you are . . .

Pregnant or think you might be?	Yes	No
Currently Nursing (Breast Feeding)?	Yes	No
Do you think you will have more children?	Yes	No

Taking Oral Contraceptives?	Yes	No
On Hormone Replacement Therapy (HRT)?	Yes	No
Do you anticipate starting HRT Soon?	Yes	No

How many times have you gone through childbirth? _____

Patient Name: _____

Date: _____

Alabama Vascular and Vein Patient Health History Form

In your own words, please describe the problem for which you are seeking our services: _____

May we send a report of our findings, recommendations findings to your family doctor? Yes No

If so, please give us the name and phone number of your family doctor: _____
Name Phone#

Please list all medications that you take at least three times per week:

Are you allergic to anything? [] Yes [] No

If yes, please list any and all allergies: _____

Family History: Please indicate if any of the following conditions were present in your immediate family members:

Varicose Veins?	Yes	No
Venous Ulcers?	Yes	No
Deep Vein Thrombosis?	Yes	No

Phlebitis?	Yes	No
A history of Vein Surgery?	Yes	No
Blood Clots?	Yes	No

Past Surgical History:

Have you ever had surgery? [] Yes [] No

If you have had surgery, what type and when? _____

Additional Medical History Not Mentioned Above:

Are you presently seeing another physician for anything NOT mentioned above? [] Yes [] No

If so, What is the Doctors Name? _____

If so, For what condition(s) is he or she treating you? _____

Have you ever been hospitalized for anything NOT mentioned above? [] Yes [] No

If so, for what, at what Hospital, and when? _____

Alabama Vascular and Vein Patient Health History Form

Review of Systems: Do you currently have any of the following?
If you check "Yes" for anything, explain on the line below the checkbox.

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional: (Fever, chills, recent unexplained loss of appetite or weight).
<input type="checkbox"/>	<input type="checkbox"/>	Eyes:(Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting).
<input type="checkbox"/>	<input type="checkbox"/>	ENT: (No recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears).
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac: (No chest pain, shortness of breath, waking from sleep breathless, or cardiac meds).
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory: (No shortness of breath, productive cough, coughing up blood, or pain with breathing).
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal: (No change in bowel habits, no black, red or bloody stools, vomiting or belly pain).
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary: (No incontinence, frequent, urgent or painful urination. No waking at night to urinate).
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal: (No change in walking ability or strength. No painful joints)
<input type="checkbox"/>	<input type="checkbox"/>	Skin: (No problematic rashes or itching, no changes in skin color or sores that won't heal)
<input type="checkbox"/>	<input type="checkbox"/>	Neurological: (No unexpected, unexplained numbness, tingling, or loss of memory or movement).
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric: (No suicidal thoughts or hallucinations)

Patient Name: _____

Date: _____