



Patient Health History Form

Name _____ Date of Visit _____

Date of Birth _____ Age _____ Sex: Male / Female

Primary Care Physician _____

Please answer all the following questions, trying not to leave any blank.

Due to the insurance industry's need to fully understand your medical needs it is necessary to complete as much of this form as necessary. This will also assist our office in assessing your particular needs for proper medical care.

Past Medical History

1) Have you ever been in the hospital as a patient? Yes No
If yes, specify when and for what reason. _____

2) Have you ever had surgery of any kind? Yes No
If yes, please specify when and what type of surgery. _____

Vein History

1) Which leg is the most bothersome to you? Right Left Equal

2) Have you ever had your veins evaluated before? Yes No
If so, what doctor and when? _____
Did this doctor perform any tests on your veins? (example: Ultrasound)

3) Do you wear support hose prescribed by a doctor? Yes No
If yes, what type and do they provide relief? Yes No

4) Do you wear light support hose (example: sheer energy) Yes No
If so, do they provide relief? Yes No

5) Have you ever had any vein surgery? Yes No
If yes, what leg? Right Left



- 6) Have you ever had vein injections? Yes No
 If yes, what leg? Right Left
- 7) Have you ever had any blood clots? Yes No
 If yes, what leg? Right Left
- 8) Have you ever had phlebitis? Yes No
 If yes, what leg? Right Left

9) Do you experience any of the following symptoms?

- | | | | | | |
|--------------------------|-----|----|-----------------|-----|----|
| Aching/pain in your legs | Yes | No | Heaviness | Yes | No |
| Tiredness/fatigue | Yes | No | Itching/burning | Yes | No |
| Swollen ankles | Yes | No | Leg Cramps | Yes | No |
| Restless Legs | Yes | No | Throbbing | Yes | No |

Any other symptoms? _____

- 10) How long have you experienced these symptoms? Months ____ Years ____
- 11) Does walking help the discomfort? Yes No
- 12) Do you stand much at work? Yes No How long? ____
 Do you stand much at home? Yes No How long? ____
- 13) How do you relieve discomfort in your legs? Elevate Walk

Comprehensive History Checklist
 (Please check all those that apply)

	Right Leg	Left Leg
Edema		
Pain		
Tiredness		
Ulceration		
Skin Color Changes		
Spider Veins		
Varicose Veins		

Current Medical History

- 14) Do you have: Medications? Medications?
- | | | | | | | | |
|---------------------|-----|----|-------|-----------|-----|----|-------|
| Heart Disease | Yes | No | _____ | Pacemaker | Yes | No | _____ |
| Lung Disease | Yes | No | _____ | Anemia | Yes | No | _____ |
| Hepatitis | Yes | No | _____ | Arthritis | Yes | No | _____ |
| Leg Ulcer | Yes | No | _____ | Diabetes | Yes | No | _____ |
| Asthma | Yes | No | _____ | Thyroid | Yes | No | _____ |
| High Blood Pressure | Yes | No | _____ | | | | |

15) Are you presently under the care of a physician? Yes No
 If yes, please indicate who and for what illness or purpose _____

