Medical History Form

FAIRFAX VEIN CENTER
AN AFFILIATE OF FAIRFAX RADIOLOGICAL CONSULTANTS

Name: _____

Date: _____ /_____ /_____ **Age:** _____ **Smoke** (Years): _____

☐ High Blood Pressure	☐ Heart Disease	☐ Hepatitis	Drug Allergies
☐ Mitral Valve Prolapse	☐ Bleeding Disorder	☐ Stroke	_____
☐ Open Heart Surgery	☐ Pulmonary Embolus	☐ Diabetes	_____
☐ Superficial Phlebitis	☐ Deep Vein Thrombosis	☐ Seizures	_____

Are you pregnant or nursing? _____Y _____N _____N/A

Family Physician: _____ Phone number: (____)_____-_____

Surgical History (List all surgeries and approximate year)

_____

_____

_____

List all medications you are currently taking _____

_____

_____

_____

Symptoms:

☐ Aching or throbbing	☐ Leg pain	☐ Red/warm areas	☐ Spider veins
☐ Tired or heavy legs	☐ Ankle/leg swelling	☐ Itching	☐ Night cramps
☐ Skin changes	☐ Ulcers or ulceration	☐ Burning pain in legs	☐ Hard lumps
☐ Leg pain	☐ Tenderness	☐ Varicose veins (bulging)	☐ Other_____

Personal History of Varicose Veins or Spider Veins:

_____ **List number of years**

Y N Related to Pregnancy?
Y N Related to Accident Trauma?
Y N Are you developing new veins?
Y N Are your present veins getting bigger?
Y N Do you smoke?
Y N Does your discomfort/leg pain interfere with your activities of daily living?

Are your symptoms worse with:

Y N Prolonged standing?
Y N Prolonged seating?
Y N Menstrual cycle?

Are your symptoms relieved with:

Y N Rest/Elevation of leg(s)?

Family History of Varicose Veins or Spider Veins:

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Uncle ☐ Aunt ☐ None

Previous Treatment History:

Y N Ligation/Stripping Surgery	If so, which leg? _____	When? _____
Y N Injection Treatments	If so, which leg? _____	When? _____
Y N Laser Therapy	If so, which leg? _____	When? _____

Y N Other_____

Patient Signature_____ **Date:** _____ /_____ /_____

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Previous conservative treatment you have tried:

Y N Do you take pain medications (☐ Advil ☐ Tylenol ☐ Aspirin) for your leg pain/veins?

Y N Have you worn compression hose or active support hose for your current problem for 6 months or longer? When? _____

Y N Did they help your symptoms (leg pain/swelling)? ☐ Totally ☐ Partially

Y N Have you been taking over the counter anti-inflammatory medications for 6 months or longer for leg pain?

Y N Do you routinely rest and elevate your legs to help relieve leg pain and/or swelling?

Y N If yes, have you done so for 6 months or longer?

Y N Has your varicose vein problem caused a physical impairment due to pain, swelling, throbbing, tired feelings, etc.?

What specifically do you feel you can no longer do because of your varicose veins?

_____

_____

_____

Y N Have you discussed your varicose vein problem with your primary care doctor or any other doctor?
If so, what did the doctor recommend that you do?

_____

_____

_____

What have you tried on your own to help alleviate your symptoms, beyond what you have already indicated?

_____

_____

_____

How did you hear about us?

☐ Friend ☐ Magazine ☐ Other_____
☐ Newspaper ☐ Doctor
☐ Internet ☐ FRC Office

Patient Signature_____ **Date:** _____ /_____ /_____

FAIRFAX
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Date