The Vein Clinic, Inc.

PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

AREAS OF CONCERN
□ Varicose Veins □ Spider Veins

GENERAL HISTORY

Age: _____

Are You: □ Pregnant? □ Planning a Pregnancy? □ Nursing?

Medications: □ None □ Aspirin □ Plavix □ Coumadin □ NSAIDS □ Birth Control

Allergies: _____

Have You Ever Has **Any** Reaction to Latex _____or Tape? _____
Have You Ever Had **Any** Reaction to a Local Anesthetic? _____
Have You Ever Had **Any** Reaction to Needle Sticks/Blood Draws, Etc? _____

Do you have a history of migraine headaches? □ Yes □ No

Do you have a heart murmur? □ Yes □ No

Previous Surgeries to Legs? _____

History Of: □ Lung Blood Clot □ Deep Vein Thrombosis □ Bleeding Disorder
□ HIV □ Hepatitis B/C □ Herpes □ None of the Above

VEIN HISTORY ***PLEASE BE SURE TO COMPLETE ALL SECTIONS***

How many years have you had a problem with Varicose and/or Spider Veins? _____

SYMPTOMS: □ None □ Burning □ Itching □ Tingling □ Cramping □ Heaviness
□ Leg Fatigue □ Leg Rash □ Pain/Discomfort □ Ulcer □ Swelling
□ Other, Explain:_____

Do you have a family history of Varicose and/or Spider Veins? □ Yes □ No

Have you ever been treated for Varicose and/or Spider Veins? □ Yes □ No

If Yes, When?_____ By Whom? _____

What Method? □ Stripping □ Ligation □ Laser □ Sclerotherapy □ Electrocautery
□Other: _____