Patient Health History George Kuefner, MD, RPVI PH 708-460-8800

PATIENT NAME____BIRTHDATE_____/_____/_____AGE_________

Weight ____________ Height ____________

What bothers you most about your vein problems?____

____

Do you experience any of the following leg symptoms?

- ◯ Pain/aching in your legs
- ◯ Itching
- ◯ Tiredness/Fatigue
- ◯ Leg cramps
- ◯ Throbbing
- ◯ Burning
- ◯ Restless Legs
- ◯ Swollen Legs or Ankles
- ◯ Bleeding
- ◯ Numbness of Legs or Feet

Other,
____
____
____

Do you elevate your legs to relieve discomfort? ◯Yes ◯No

Do you wear light support hose? ◯Yes ◯No

Do you wear prescribed support hose? ◯Yes ◯No If yes, do they provide relief? ◯Yes ◯No

Does standing affect your legs? ◯Yes ◯No If yes, please explain:______________________________

Do you have any problem walking? ◯Yes ◯No If yes, please explain:______________________________

Can you walk one hour a day? ◯Yes ◯No

Have your veins deteriorated in recent months? ◯Yes ◯No

Have you had testing or evaluation of your veins? ◯Yes ◯No If yes, when and where?

____

Have you had any vein treatment Surgery, Injections and/or Laser Treatment ◯Yes ◯No If yes, when and where?

____

Do you have any dilated veins or varicose veins on your abdomen? ◯Yes ◯No

Have you ever had a blood clot (phlebitis) and/or pulmonary embolism? ◯Yes ◯No If yes, when?_____________

____

____

Family History

Anyone in your family: Has or Had varicose veins, spider veins, leg ulcers or swollen legs? ◯Yes ◯No

◯Father ◯Mother ◯Sister(s) ◯Brother(s) ◯Other______________________________

Has or Had a blood clot (phlebitis) or pulmonary embolism? ◯Yes ◯No

◯Father ◯Mother ◯Sister(s) ◯Brother(s) ◯Other______________________________

Medications

Are you presently taking prescription and/or non-prescription medications? ◯Yes ◯No If yes, list them________________

____

____

Are you taking any blood thinning medications? ◯Yes ◯No If yes, list name and dosage______________________________

Are you taking any hormone replacement, testosterone, estrogen, progesterone, Tamoxifen, Minocycline, Birth Control Pills, Evista or any topical hormone agents? ◯Yes ◯No

If yes,please circle and/or list them____

Do you smoke? ◯Yes ◯No

ALLERGIES ◯I do not have any known Allergies

Are you allergic to any of the following?

◯ Aspirin/Motrin/Advil ◯Latex ◯Local Anesthetics ◯Sulfa Drugs ◯Antibiotics/Penicillin ◯Heparin

◯ Other ____

Please explain type of reaction:____

____

Women: Are you / Do you

Pregnant/Trying to get pregnant? O Yes O No

Breast feeding? O Yes O No

Taking hormones, Estrogen/Progesterone or Birth Control Pills? O Yes O No

How many children do you have?___________

How many times have you been pregnant?___________

Intend to have more children? O Yes O No

Date of your last menstrual period _______/_______/________

Have leg discomfort before or during menstrual cycle? O Yes O No

Have vaginal varicose veins? O Yes O No

History of spontaneous miscarriages ,stillbirths and/or preeclampsia? O Yes O No If yes ,explain______________________________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes	O No	Epilepsy/Seizures	O Yes	O No	Kidney Problems	O Yes	O No
Alzheimer's Disease	O Yes	O No	Excessive Bleeding	O Yes	O No	Leukemia	O Yes	O No
Anaphylaxis	O Yes	O No	Excessive Thirst	O Yes	O No	LiverDisease/Jaundice	O Yes	O No
Anemia	O Yes	O No	FaintingSpells/Dizziness	O Yes	O No	Lung Disease	O Yes	O No
Angina	O Yes	O No	Frequent Cough	O Yes	O No	Mitral Valve Prolapse	O Yes	O No
Arthritis/Gout	O Yes	O No	FrequentHeadaches	O Yes	O No	Psychiatric Care	O Yes	O No
Artificial Heart Valve	O Yes	O No	HayFever	O Yes	O No	Radiation Treatments	O Yes	O No
Artificial Joint	O Yes	O No	Heart Attack/Failure	O Yes	O No	Recent Weight Loss	O Yes	O No
Asthma	O Yes	O No	Heart Murmur	O Yes	O No	Rheumatic Fever	O Yes	O No
Blood Disease	O Yes	O No	Heart Pacemaker	O Yes	O No	Sickle Cell Disease	O Yes	O No
Breathing Problem	O Yes	O No	Heart Trouble/Disease	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Cancer	O Yes	O No	Bleeding or Clotting Disorders	O Yes	O No	Stroke	O Yes	O No
Chemotherapy	O Yes	O No	Hepatitis A	O Yes	O No	Swelling of Limbs	O Yes	O No
Congenital Heart Disorder	O Yes	O No	Hepatitis B or C	O Yes	O No	Thyroid Disease	O Yes	O No
Convulsions	O Yes	O No	High Blood Pressure	O Yes	O No	Tuberculosis	O Yes	O No
Cortisone Medications	O Yes	O No	High Cholesterol	O Yes	O No	Tumors and Growths	O Yes	O No
Diabetes	O Yes	O No	Hives or Rash	O Yes	O No	Stomach Ulcers	O Yes	O No
Drug Addictions	O Yes	O No	Hypoglycemia	O Yes	O No	Ulcerative Colitis/Crohn's	O Yes	O No
Emphysema	O Yes	O No	Irregular Heartbeat	O Yes	O No	Heparin induced thrombosis	O Yes	O No

Have you ever been hospitalized? O Yes O No

If yes, please explain:____

____

____

Have you ever had surgery? O Yes O No

If yes, please explain____

____

____

Are you under a physicians care now? O Yes O No

If yes, please explain:____

Have you ever had a serious Illness not mentioned above? O Yes O No If yes, please explain______________________________

Comments:____

____

I understand that providing complete information of my health history is of the upmost importance,

I will continue to provide and notify Dr. Kuefner's office of any changes in my medical status.

Signature of Patient, Parent or Guardian____DATE______/_______/______