Patient Health History

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PATIENT NAME________________________ BIRTHDATE _____/_____/_____AGE______

Weight __________ LBS Height ______ FT ______IN

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 (PE)? ○ 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

Medication	Dosage	Medication	Dosage	Medication	Dosage

○ **I Do Not Have Any Known Allergies**

Are you allergic to any of the following? ○ Yes ○ No
○ Aspirin /Motrin /Advil ○ Latex ○ Local Anesthetics ○ Sulfa Drugs ○ Antibiotics/Penicillin ○ Heparin
If Yes, Explain type of reaction ______________________________
Any other allergies? ______________________________

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

WOMEN ONLY: Section

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
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 or preeclampsia? 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 _____/_____/_____

If yes, explain_________________________________

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

Condition			Condition			Condition		
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
			Infection of Concern/ MRSA or any Resistant Infections	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/Guardian ____ DATE ______/_______/_______