DATE:_____ *CARDIAC ASSOCIATES* *ACCT. #:*_____

NEW PATIENT VENOUS HEALTH HISTORY FORM

Patient Name:_____**D.O.B.**_____ Age:_____

COMPLAINT: (check all applicable)

__VARICOSE VEINS
__BLEEDING
__ULCERATIONS
__SPIDER VEINS
__RESTLESS LEG SYND
__RETICULAR VEINS
__SWELLING
__LEG CRAMPS
__ITCHING
__BURNING
__HEAVINESS
__INFLAMATION
__SKIN RASH/DISCOLORATION
__PAIN/TIREDNESS/FATIGUE
__NUMBNESS OR TINGLING IN LEGS
__REDDENED/HARD KNOT IN VEIN

WHICH LEG? _____RIGHT, _____LEFT, _____BOTH;

HOW LONG? _____(# MONTHS?) _____(YEARS?)

WORSE WHEN?: (CIRCLE)

SITTING, WALKING, MENSTRUAL CYCLE, WORKING, PREGNANCY, STANDING, BEGINNING OF DAY, END OF DAY, LYING DOWN

IMPROVED BY: (CIRCLE)

REST, ELEVATION, COMPRESSION SOCKS, FLUID PILLS, WALKING, TYLENOL/MOTRIN EQUIVALENT, WALKING, BEGINNING OF DAY, END OF DAY.

PREVIOUS VEIN TREATMENT:

_____
_____
_____
_____
_____

PAST MED HISTORY:

1. HAVE YOU EVER HAD VEIN STRIPPING SURGERY?

___YES ___NO IF YES, WHEN / WHICH LEG? _____

_____

2.HAVE YOU EVER HAD VEIN INJECTIONS?

___YES ___NO IF YES, WHEN, WHICH & WHERE ON LEG?

_____

_____

3. HAVE YOU EVER HAD A BLOOD CLOT?

___YES ___NO IF YES, WHICH LEG AND WHEN?

_____

_____

4. HAVE YOU EVER HAD PHLEBITIS? ___YES ___NO

If more space is needed, please use the back of this form.

M.D. Initials_____ , Date:_____