

Health Questionnaire

Name: _____
 Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Medical History

Do you now or have you had:

- | | | | |
|---------------------------------|------------------------------------|-----------------------------------|-------------|
| Varicose vein problems | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Redness or tenderness of a vein | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Superficial Vein Thrombosis | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Leg/ankle/foot fracture | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |

If you have ever been treated for these conditions, please describe: _____

How do the veins bother you?

- sharp pain aches/discomfort congestion/pressure swelling itching appearance

Have you had previous injection sclerotherapy of your veins? No Yes When? _____

Have you tried previous treatment for your varicose veins, such as:

- Compression stockings Weight loss Leg elevation No Yes When? _____

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

- | | | | |
|--|-----------------------------|------------------------------|-------------|
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Thyroid disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| High blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Heart disease or heart attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Jaundice or hepatitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Weight change of more than 10 lbs in last 6 mo | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Easy bruising or bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Leg pain caused by walking | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Major injury or surgery of legs | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |

Number of pregnancies: _____ Number of deliveries: _____ Dates: _____

Are you now pregnant? No Yes Breast feeding? No Yes

List hormones you have taken (including birth control pills): _____

Dates used: _____

List current medications you are taking and dosages: _____

List previous surgeries/dates: _____

Smoking history: Never Yes- What, when and how much? _____

List all drug allergies: None Latex Iodine/X-ray dye Other _____

Please describe allergic reaction: _____

Family History

Has a member of your family had any of the following:

- | | | | |
|----------------------------|-----------------------------|------------------------------|------------|
| Blood clots | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Blood coagulation disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Stroke or heart attack | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Pulmonary embolism | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Varicose veins | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |

Your signature

Today's date