



IMPROVE YOUR QUALITY OF LIFE! <sup>SM</sup>

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**MEDICAL HISTORY: MEN**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Do You Have?**

**Location-Leg (Circle)**

- |   |   |   |      |
|---|---|---|------|
| <input type="checkbox"/> Red Spider Veins                             | R | L | Both |
| <input type="checkbox"/> Purple Veins                                 | R | L | Both |
| <input type="checkbox"/> Bulging Veins                                | R | L | Both |
| <input type="checkbox"/> Flat Blue Green Veins                        | R | L | Both |
| <input type="checkbox"/> Skin Discoloration Below the Knee            | R | L | Both |
| <input type="checkbox"/> Bleeding from Veins                          | R | L | Both |
| <input type="checkbox"/> Restless Legs                                | R | L | Both |
| <input type="checkbox"/> Leg Ulcers                                   | R | L | Both |
| <input type="checkbox"/> Abdominal Veins                              |   |   |      |
| <input type="checkbox"/> Abnormal Veins of the Labia or Private Parts |   |   |      |

**Symptoms:**

- |  |   |   |      |
|--|---|---|------|
| <input type="checkbox"/> <b><u>Pain</u></b>                  | R | L | Both |
| <input type="checkbox"/> <b><u>Aching</u></b>                | R | L | Both |
| <input type="checkbox"/> <b><u>Tenderness</u></b>            | R | L | Both |
| <input type="checkbox"/> <b><u>Cramping</u></b>              | R | L | Both |
| <input type="checkbox"/> <b><u>Tired/Heavy Sensation</u></b> | R | L | Both |
| <input type="checkbox"/> <b><u>Itching</u></b>               | R | L | Both |
| <input type="checkbox"/> <b><u>Restless Legs</u></b>         | R | L | Both |
| <input type="checkbox"/> <b><u>Swelling</u></b>              | R | L | Both |

How does your condition limit or change your daily activities?

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What do you not do because of your problem? Pain? Timing of discomfort or swelling?

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What methods have you used to relieve your leg discomfort?

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Leg Elevation                  | <input type="checkbox"/> Elastic Wraps   | <input type="checkbox"/> Aspirin      |
| <input type="checkbox"/> Exercise                       | <input type="checkbox"/> Warm Soaks      | <input type="checkbox"/> Walking      |
| <input type="checkbox"/> Flexion/Extension of the ankle | <input type="checkbox"/> Cold Compresses | <input type="checkbox"/> Others _____ |

				<b>(Circle One)</b>	
				<b>Y</b>	<b>N</b>
Have you worn elastic support hose?	How long? _____ months				
Calf?	Thigh?	Pantyhose?	Compression Rating:	<15mm 20-30mm	15-20mm 30-40mm
Have you taken pain medication for your veins? How long? _____				<b>Y</b>	<b>N</b>
If yes, What medication? _____					
Do you elevate your legs for relief? Hours/Day _____				<b>Y</b>	<b>N</b>
Have you had any weight changes of 10 lbs or more in the past year?					
				<b>Y</b>	<b>N</b>
Have you ever been tested for or found positive for a Patent Foramen Ovale (PFO) or Atrial Septal Defect (ASD)?				<b>Y</b>	<b>N</b>

**Please list other health problems:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Ankle skin changes              | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Atherosclerosis (hardening of the arteries) | <input type="checkbox"/> Kidney disease                  | <input type="checkbox"/> Bleeding/blood disorder            |
| <input type="checkbox"/> Chest pain discomfort                       | <input type="checkbox"/> Liver disease                   | <input type="checkbox"/> Constipation                       |
| <input type="checkbox"/> Crohn's disease, IBS                        | <input type="checkbox"/> Migraine headaches              | <input type="checkbox"/> Migraine with aura                 |
| <input type="checkbox"/> Mitral valve prolapse                       | <input type="checkbox"/> Easy bruising                   | <input type="checkbox"/> Pulmonary embolus                  |
| <input type="checkbox"/> HIV   | <input type="checkbox"/> Lupus                           | <input type="checkbox"/> Heart disease                      |
| <input type="checkbox"/> Rupture of a vein                           | <input type="checkbox"/> Hepatitis                       | <input type="checkbox"/> Trauma to legs                     |
| <input type="checkbox"/> Diabetes, insulin dependent                 | <input type="checkbox"/> Diabetes, non-insulin dependent |   |
| <input type="checkbox"/> Other _____                                 | <input type="checkbox"/>                                 |   |

Do you have any allergies to iodine or shellfish?	<b>Y</b>	<b>N</b>	
Do you have problems with tape?	<b>Y</b>	<b>N</b>	What kind? _____
Are you latex sensitive?	<b>Y</b>	<b>N</b>	Reaction _____
Do you smoke?	<b>Y</b>	<b>N</b>	____packs/day <input type="checkbox"/> cigarettes <input type="checkbox"/> pipe, cigar
Do you consume alcohol?	<b>Y</b>	<b>N</b>	____drinks/week
Do you consume recreational drugs?	<b>Y</b>	<b>N</b>	Type _____

**Current Medications: (Include hormone and pain medications)**

Drug	Dose	Frequency	Route (Oral, Injectable)

**Drug Intolerances/Allergies:**

Drug	Reaction/Sensitivity

**Have you ever had any of the following:**

	<u>Location</u>		<b>(circle)</b>
Injury requiring surgery to the leg or casting?	R	L	Both
Blood clot in the Deep Veins (DVT)?	R	L	Both
Phlebitis (Superficial veins, SVT)?	R	L	Both
Venous Stasis Ulcer?	R	L	Both
Sclerotherapy?	R	L	Both
LASER Treatment of the Legs?	R	L	Both
Vein Stripping?	R	L	Both
Phlebectomy?	R	L	Both
Thermal Ablation?    Radiofrequency    LASER	R	L	Both
Major Leg Surgery	R	L	Both

PAST SURGICAL HISTORY:            (List Procedures and dates)

FAMILY MEDICAL HISTORY:

**FAMILY HISTORY:**

Is there a history in your **FAMILY** of spider or varicose veins?

Describe which:

- |  |  |
|--|--|
| <input type="checkbox"/> Mother _____                | <input type="checkbox"/> Siblings _____              |
| <input type="checkbox"/> Father _____                | <input type="checkbox"/> Maternal Aunt/Uncle _____   |
| <input type="checkbox"/> Paternal Aunt/Uncle _____   | <input type="checkbox"/> Paternal Grandparents _____ |
| <input type="checkbox"/> Paternal Grandparents _____ | <input type="checkbox"/> Child _____                 |

Is there a history in your **FAMILY** of deep venous thrombosis, stroke or clotting disorders?

Describe which:

- |  |  |
|--|--|
| <input type="checkbox"/> Mother _____                | <input type="checkbox"/> Siblings _____              |
| <input type="checkbox"/> Father _____                | <input type="checkbox"/> Maternal Aunt/Uncle _____   |
| <input type="checkbox"/> Paternal Aunt/Uncle _____   | <input type="checkbox"/> Maternal Grandparents _____ |
| <input type="checkbox"/> Paternal Grandparents _____ | <input type="checkbox"/> Child _____                 |

**Review of Systems: Do you currently have any of the following?**  
**If you check "Yes" for anything, explain on the line below the checkbox.**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional: (Fever, chills, recent unexplained loss of appetite or weight).
<input type="checkbox"/>	<input type="checkbox"/>	Eyes: (Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting).
<input type="checkbox"/>	<input type="checkbox"/>	ENT: (Recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears).
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac: (Chest pain, shortness of breath, waking from sleep breathless, or cardiac meds).
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory: (Shortness of breath, productive cough, coughing up blood, or pain with breathing).
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal: (Change in bowel habits, black, red or bloody stools, vomiting or belly pain).
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary: (Incontinence, frequent, urgent or painful urination, waking at night to urinate).
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal: (Change in walking ability or strength. Painful joints).
<input type="checkbox"/>	<input type="checkbox"/>	Skin: (Problematic rashes or itching, changes in skin color or sores that won't heal).
<input type="checkbox"/>	<input type="checkbox"/>	Neurological: (Unexpected, unexplained numbness, tingling, or loss of memory or movement).
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric: (Panic attacks, excessive anxiety, severe depression).

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Date Reviewed: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient Health History for an Initial Office Visit**