VEINCARE CENTERS OF TENNESSEE

IMPROVE YOUR QUALITY OF LIFE! SM

## MEDICAL HISTORY: ***WOMEN***

**Name:**_____ **Date:**_____

**Age:**_____ **Height:**_____ **Weight:**_____ **Occupation:** _____

| **Do You Have?** | **Location-Leg (Circle)** | | |
|---|---|---|---|
| ☐ Red Spider Veins | R | L | Both |
| ☐ Purple Veins | R | L | Both |
| ☐ Bulging Veins | R | L | Both |
| ☐ Flat Blue Green Veins | R | L | Both |
| ☐ Skin Discoloration Below the Knee | R | L | Both |
| ☐ Bleeding from Veins | R | L | Both |
| ☐ Restless Legs | R | L | Both |
| ☐ Leg Ulcers | R | L | Both |
| ☐ Abdominal Veins | | | |
| ☐ Abnormal Veins of the Labia or Private Parts | | | |

**Symptoms:**

| | | | |
|---|---|---|---|
| ☐ **Pain** | R | L | Both |
| ☐ **Aching** | R | L | Both |
| ☐ **Tenderness** | R | L | Both |
| ☐ **Cramping** | R | L | Both |
| ☐ **Tired/Heavy Sensation** | R | L | Both |
| ☐ **Itching** | R | L | Both |
| ☐ **Restless Legs** | R | L | Both |
| ☐ **Swelling** | R | L | Both |

How does your condition limit or change your daily activities?

_____

_____

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

_____

_____

What methods have you used to relieve your leg discomfort?

| | | |
|---|---|---|
| ☐ Leg Elevation | ☐ Elastic Wraps | ☐ Aspirin |
| ☐ Exercise | ☐ Warm Soaks | ☐ Walking |
| ☐ Flexion/extension of the ankle | ☐ Cold Compresses | ☐ Others _____ |

**(Circle One)**

Have you worn elastic support hose? How long? ____ months **Y** **N**

Calf? Thigh? Pantyhose? Compression Rating: < 15mm 15-20mm 20-30mm 30-40mm

Have you taken pain medication for your veins? How long?___ **Y** **N**

If yes, what medication? _____

Do you elevate your legs for relief? Hours/Day ____ **Y** **N**

Have you had any weight changes of 10 lbs or more in the past year? ⬆ ⬇ **N**

Do you exercise? ☐ Mild/occasional ☐ Routine ☐ Intense Exercise

How many children have you carried to delivery? _____

How many stillbirths or spontaneous miscarriages? _____

Do you have Pelvic Pain? ☐ Before or during menses ☐ During or shortly after intercourse

☐ How long before pain resolves? _____

Do you have bulging or painful varicose veins in the female organs? **Y** **N**

*Do you have more leg discomfort during or around your menstrual period?* **Y** **N**

*Are you pregnant or planning pregnancy soon?* **Y** **N**

*Are you breastfeeding currently?* **Y** **N**

*Have you ever been tested for or found positive for a Patent Foramen Ovale (PFO) or Atrial Septal Defect (ASD)?* **Y** **N**

**Please list other health problems:**

☐ Anemia
☐ Atherosclerosis (hardening of the arteries)
☐ Chest pain discomfort
☐ Chrohn's disease, IBS
☐ Mitral valve prolapse
☐ HIV
☐ Rupture of a vein
☐ Diabetes, insulin dependent
☐ Other_____
☐ Ankle skin changes
☐ Kidney disease
☐ Liver disease
☐ Migraine headaches
☐ Easy bruising
☐ Lupus
☐ Hepatitis
☐ Diabetes, non-insulin dependent
☐
☐ Hypertension (high blood pressure)
☐ Bleeding/blood disorder
☐ Constipation
☐ Migraine with aura
☐ Pulmonary embolus
☐ Heart disease
☐ Trauma to legs

Do you have any allergies to iodine or shellfish? **Y** **N**

Do you have problems with tape? **Y** **N** What kind?_____

Are you latex sensitive? **Y** **N** Reaction_____

Do you smoke? **Y** **N** ____packs/day ☐ cigarettes ☐ pipe, cigar

Do you consume alcohol? **Y** **N** ____drinks/week

Do you consume recreational drugs? **Y** **N** Type_____

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

| Drug | Dose | Frequency | Route (Oral, Injectable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |
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**Drug Intolerances/Allergies:**

| Drug | Reaction/Sensitivity |
|---|---|
| | |
| | |
| | |
| | |
| | |

| **Have you ever had any of the following:** | **Location** | | **(circle)** |
|---|---|---|---|
| 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 (specify maternal or paternal):

FAMILY HISTORY:

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

Describe which:

☐ Mother ☐ Siblings ☐ Maternal Grandmother ☐ Maternal Aunt/Uncle
☐ Paternal Aunt/Uncle ☐ Father ☐ Maternal Grandfather ☐ Child
☐ Paternal Grandfather ☐ Paternal Grandmother

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

Describe which:

☐ Mother ☐ Siblings ☐ Maternal Grandmother ☐ Maternal Aunt/Uncle
☐ Paternal Aunt/Uncle ☐ Father ☐ Maternal Grandfather ☐ Child
☐ Paternal Grandfather ☐ Paternal Grandmother

**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 | |
|---|---|---|
| ☐ | ☐ | Constitutional: (Fevers, chills, recent unexplained loss of appetite or weight). |
| | | |
| ☐ | ☐ | Eyes: (Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting). |
| | | |
| ☐ | ☐ | ENT: (Recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears). |
| | | |
| ☐ | ☐ | Cardiac: (Chest pain, shortness of breath, waking from sleep breathless, or cardiac meds). |
| | | |
| ☐ | ☐ | Respiratory: (Shortness of breath, productive cough, coughing up blood, or pain with breathing). |
| | | |
| ☐ | ☐ | Gastrointestinal: (Change in bowel habits, black, red or bloody stools, vomiting or belly pain). |
| | | |
| ☐ | ☐ | Genitourinary: (Incontinence, frequent, urgent or painful urination, waking at night to urinate). |
| | | |
| ☐ | ☐ | Musculoskeletal: (Change in walking ability or strength. Painful joints). |
| | | |
| ☐ | ☐ | Skin: (Problematic rashes or itching, changes in skin color or sores that won't heal). |
| | | |
| ☐ | ☐ | Neurological: (Unexpected, unexplained numbness, tingling, or loss of memory or movement). |
| | | |
| ☐ | ☐ | Psychiatric: (Panic attacks, excessive anxiety, severe depression). |
| | | |