PATIENT'S HEALTH HISTORY (by Patient)

Patient's Name: _____ **DOB:** ___/___/____ Age: _____ Date_____

Present Medications and Doses:	1.	2.	3.
Name and location of your Pharmacy			
Medication Allergies:	1.	2.	3.
Other Allergies:	1.	2.	3.
Are you currently Pregnant? ☐YES ☐NO		**Are you currently on birth control pills**? ☐YES ☐NO	
Number of pregnancies:		**Number of Children:**	

PAST MEDICAL HISTORY:

Hospitalizations, Operations or Past Illness:

YOUR CURRENT MEDICAL PROBLEMS:

☐ Hypertension ☐ Coronary Artery Disease ☐ Diabetes ☐ Thyroid (hyper or hypo) ☐ COPD ☐ **Peripheral Arterial Disease**

☐ **Varicose Veins** ☐ **Spider Veins** ☐ **Swollen legs** ☐ **Other**_____

SOCIAL HISTORY:

Smoke: ☐YES ☐NO #of packs per day: **Previous Smoker:** ☐YES ☐NO **Alcohol**: ☐YES ☐NO ☐MILD ☐MODERATE ☐HEAVY

FAMILY HISTORY (check all that apply)

☐ Asthma ☐ Diabetes ☐ Tuberculosis ☐ High Blood Pressure ☐ Autoimmune Disease ☐ **Varicose Veins** (☐ Father ☐ Mother ☐ Sibling)

☐ Cancer ☐ Allergies ☐ Heart Disease ☐ Bleeding Problems ☐ Anesthesia Problems ☐ Stroke ☐ Other

REVIEW OF SYSTEMS (check if any medical problems associated with the following systems)

HEAD:	☐ Headaches	☐ Other:			
NECK:	☐ Lumps	☐ Thyroid nodules	☐ Pain	☐ Swollen glands	☐ Surgery
EYES:	☐ Loss of vision	☐ Glaucoma	☐ Eye disease	☐ Other:	
EARS:	☐ Hearing loss	☐ Pain	☐ Discharge	☐ Other:	
NOSE:	☐ Discharge	☐ Stuffiness	☐ Post nasal drip	☐ Other:	
THROAT:	☐ Soreness	☐ Throat clearing	☐ Lump	☐ Recent dental work	
CHEST:	☐ Cough	☐ Asthma	☐ Tuberculosis	☐ Chronic lung disease	☐ Shortness of breath
CARDIO VASCULAR:	☐ High blood pressure	☐ Heart problems	☐ Other:		
VASCULAR EXTREMITIES:	☐ Varicose / Spider veins	☐ Pain in legs when walking	☐ Ankle swelling	☐ Easy bruising	☐ Anemia /Bleeding problems
DIGESTIVE:	☐ Stomach pain	☐ Indigestion	☐ Reflux	☐ Nausea /Vomiting	☐ Intestinal problems
BLADDER /KIDNEYS:	☐ Blood in urine	☐ Problems urinating	☐ Kidney disease	☐ Prostate problems	☐ Other:
MENTAL STATUS:	☐ Anxiety	☐ Depression	☐ Memory loss	☐ Other:	

I certify that this information is true and correct to the best of my knowledge. If any changes occur in the future, I will notify the office. I authorize the release of any medical information necessary to process my insurance claims. I understand if my insurance company does not cover any of the services, I will be responsible for the payment.

_____ _____ _____ _____

Signature of Patient **Date** **Physician's Initials** **Staff initials**

PATIENT'S VENOUS HISTORY (by Patient)

Patient's Name: _____DOB: ___/___/____Age: _____ Date: _____

SYMPTOMS (To be completed by Patient)		
Please read carefully and answer the following questions below (check **right**, **left** or **both** if you have any of these symptoms)? Approximately, how long have you had these symptoms? _____ **Exercise**: How often? ☐ Daily ☐Seldom ☐ 2-3 times/week		
Pain in the legs ☐ Dull ☐ Aching ☐ Sharp ☐Throbbing	☐Right	☐Left
Heaviness and tiredness of the legs (after being on feet for many hours)	☐Right	☐Left
Cramping of the legs (this includes calves and feet)	☐Right	☐Left
Restless legs *(Constant movements of legs at night to get relief)*	☐Right	☐Left
Itching of the skin of the legs	☐Right	☐Left
Burning of the skin of the legs	☐Right	☐Left
Swelling of the legs (this includes ankle and feet)	☐Right	☐Left
Bleeding from the veins of the legs	☐Right	☐Left
Frequent Bruising of legs spontaneously or with minor trauma	☐Right	☐Left
Pigmentation Changes of the legs	☐Right	☐Left
Phlebitis in the past *(Clot in surface veins in legs)*	☐Right	☐Left
Blood Clots in the Deep Vein of the legs (in the past)**-DVT**	☐Right	☐Left
Pulmonary Embolism (blood clot in lungs)	☐Yes	☐No
Varicose veins	☐Right	☐Left
Spider veins	☐Right	☐Left
Have you ever worn **compression stockings** for your legs?	☐ Yes **HOW LONG?**	☐No
Do the support stockings provide relief?	☐ Yes	☐No
Do you take **over the counter medicine** for relief of leg pain?	☐ Yes	☐No
Have you ever had Vein Procedures? ☐ Stripping ☐Closure	☐Yes	☐No
Have you ever had local removal of bulging varicose veins?	☐Yes	☐No
Do you stand much at work?	☐Yes	☐No
Do you stand much at home?	☐Yes	☐No
Do you notice new veins appearing on your legs?	☐Yes	☐No
Are you allergic to latex?	☐ Yes	☐No
Are you allergic to any surgical tape?	☐Yes	☐No
Do you have sleep apnea?	☐ Yes	☐No

I have answered all the above questions to the best of my knowledge and understanding. Nobody in the office influenced me. In the future, if my symptoms change, I will notify the office. Dr. Ahmad thoroughly discussed the above with me.

_____ _____ _____

Patient's Signature: (stating the above is true)**:** **Physician's Signature:** **Date:**

Details of Symptoms

Please fill this form by marking all that applies to you

- **Pain**

Type of pain:

- ☐ Dull aching
- ☐ Burning
- ☐ Sharp
- ☐ Cramping
- ☐ Throbbing
- ☐ Itching
- ☐ Heaviness and tiredness

Severity of Pain

- **Scale of one to ten** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10**
- **Factors aggravating the pain** e.g., prolonged *standing* _____
- **Factors relieving the pain** e.g., *lying flat* _____

- **Swelling** *(When is the swelling worse?)*

☐ in AM ☐ in PM ☐ after walking ☐ after standing for several hours

☐ After resting

- **Compression stockings** (*How long you have been wearing the stockings?)*

☐ Less than 3 months ☐ More than 3 months ☐ 6 months

☐ 1 year ☐ 2 years ☐ many years

I have answered all the above questions to the best of my knowledge and understanding. Nobody in the office influenced me. In the future, if my symptoms change, I will notify the office. Dr. Ahmad thoroughly discussed the above with me.

Patient's Signature: (stating the above is true)**:** _____ **Physician's Signature:** _____ **Date:** _____