

PATIENT'S HEALTH HISTORY (by Patient)

Front & Back

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	Stiffness	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 (<i>Constant movements of legs at night to get relief</i>)	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 (<i>Clot in surface veins in legs</i>)	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: