### Family History

- [ ] Diabetes
- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Stroke

### Personal History

- [ ] Pacemaker/ICD

### Social History

- [ ] AIDS/HIV
- [ ] Asthma
- [ ] Cancer
- [ ] Congestive Heart Failure
- [ ] Diabetes
- [ ] Emphysema/COPD (Lung Disease)
- [ ] Gout
- [ ] Heart Attack

### Women Only

- [ ] Hiatal Hernia/Reflux
- [ ] High Blood Pressure

### Men Only

- [ ] Chest Pain/Pressure/Discomfort

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**Have you had any of the following procedures?**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>If so, when/where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Diabetes</td>
<td>Angioplasty/Stent</td>
</tr>
<tr>
<td>[ ] Heart Attack</td>
<td>Heart/Blood Vessel Surgery</td>
</tr>
<tr>
<td>[ ] High Blood Pressure</td>
<td>Heart Catheterization</td>
</tr>
<tr>
<td>[ ] High Cholesterol</td>
<td>Heart Valve Replacement</td>
</tr>
</tbody>
</table>

**Have you had your annual wellness check/follow up in the last 12 months?**

- [ ] Yes
- [ ] No

**Social History**

- Smoking?
  - [ ] Yes
  - [ ] No
- Alcoholic Beverages?
  - [ ] Yes
  - [ ] No
- Exercise?
  - [ ] Yes
  - [ ] No

**Women Only**

- Do you take oral contraceptives?
- Are you pregnant?

**Men Only**

- Are you pregnant?
Patient information

For:
Date of Birth:
MRN:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Dizziness</td>
<td>Prostate Problems?</td>
</tr>
<tr>
<td>[ ] Edema (Swollen legs, ankle or feet)</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] Fatigue</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Heartburn</td>
<td></td>
</tr>
<tr>
<td>[ ] Irregular Heart Beats or Palpitations</td>
<td>Are you allergic to any medications?</td>
</tr>
<tr>
<td>[ ] Leg Pain when Walking</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] Nausea/Vomiting/Abdominal Discomfort</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Shortness of Breath</td>
<td>If yes, please list below:</td>
</tr>
<tr>
<td>[ ] Sleep Disorder</td>
<td></td>
</tr>
</tbody>
</table>

Hospitalization Information

To Ensure we have accurate records for your visit today, please clearly complete this section.

Venous Disease Questionnaire

Do you have family members with venous disease?

[ ] Yes

Have you been a patient at any hospital within the past six (6) months?

[ ] No

[ ] Yes [ ] No

Do you sit or stand for long period of time?

[ ] Yes

If yes, which hospital for the first occurrence:

[ ] No

Approximate dates of hospitalization:

[ ] Yes

From: [ ] No

To: Do you have swelling in your legs?

[ ] Yes

Which Hospital for the second occurrence:

[ ] No

Do you have varicose or spider veins? (visible veins on your legs)

Approximate dates of hospitalization:

[ ] Yes

From: [ ] No

To: Do you have skin discoloration below your knees?

[ ] Yes

Which Hospital for the third occurrence:

[ ] No

Have you ever had or currently have an ulcer on your legs?

Approximate dates of hospitalization:

[ ] Yes

From: [ ] No

To: Have you ever had a blood clot in your legs or pulmonary embolism?

[ ] Yes

[ ] No
Patient information

For:
Date of Birth:
MRN: