Medical Questionnaire

VEIN CENTRE

Date _____ Social Security _____ Date of Birth _____
Name _____
Address _____
City, State, ZIP _____
Home Phone _____ Cell Phone _____
Gender ___ Age ____ Height _____ Weight _____ BP_____
Primary Care Physician _____ Phone Number _____
Place of Employment _____ Phone Number _____
Occupation _____ Work Phone _____ e-mail _____
Emergency Contact and Relationship _____ Phone Number _____
Pharmacy Name _____ Phone Number _____
How did you hear about the Vein Centre? (please check all that apply) ☐ TV *(Channel 4, More at Midday or Better Nashville?)*

☐ Physician (If so, whom may we thank?) _____
☐ Friend (If so, whom may we thank?) _____
☐ Website (veinreliever.com or WSMV.com) _____

1 How long have you been having problems with your veins? _____
2 Please circle the type of symptoms that you have been having:

Tired/Heavy Sensations	Skin Ulcers	Skin Changes	Pain in Legs during Exercise
Aching Legs	Bleeding	Numbness	Swelling (Legs or ankles)
Throbbing or Cramping Pain	Itching	Tingling	Pain in legs while resting
	Burning Pain	Phlebitis	Skin Discoloration

3 Have your veins become worse in the past several months? _____
4 Insurance requires 3 months of support hose use. Have you worn support hose and for how long?_____
5 Have you taken any analgesic medication for the pain? _____
6 Have you ever been treated for vein problems? _____
If yes, by whom, when and where _____

7 Do you have a family history of vein symptoms (varicose veins, spider veins, leg ulcers, blood clots or swollen legs?)_____
8 Do you have a personal history of the following? (Check all that apply)

Blood clots/Phlebitis	Thyroid	Hepatitis	Heart Disease
Diabetes	Asthma	High Blood Pressure	Migraines/Headaches
Stroke	Seizures	Vascular Disease	Fainting/Dizziness

9 Do you have a family history of blood clots or phlebitis?_____
10 Please list all allergies _____
Are you allergic to local anesthesia ?_____
11 List all medications that you are currently taking: (include birth control pills/hormones or blood thinners)
_____
_____
12 When was your last menstrual period? _____ Number of Pregnancies _____
13 Tobacco use (includes snuff, cigars, cigarettes, etc) ___ YES ___ Not Now ___ Never
Indicate Usage (Packs per day, cigarettes per day, cans per day, etc) _____
14 Please list all previous surgeries _____
_____

Patient Signature _____ Date _____

Physician Signature _____ Date_____