Medical Questionnaire

Date:

Social Security:

Date of Birth:

Name: Patient Account #:

Address: Email:

Home Phone: Cell Phone:

Gender:

Age: Height:

Weight:

BP:

HR:

Temp:

Pain Level:

Primary Care Physician: Place of Employment: Occupation:

Phone Number: Phone Number: Phone Number:

Emergency Contact:

Pharmacy Name:

Relationship: Phone Number:

Phone Number:

How did you hear about the Vein Centre? (please check all that apply)

* Physician (if so, whom may we thank?)
* Friend (If so, whom may we thank?)
* TV (channel 2, channel 4 or channel 5?)
* Website (veinreliever.com)
* Social Media (Instagram, Facebook, Twitter, Youtube)
1. How long have you been having problems with your veins?
2. Please Check the Box(s) that describe any symptoms you have been having.

|  |  |  |
| --- | --- | --- |
| □ Tired/Heavy Sensations | □ Bleeding | □ Phlebitis |
| □ Aching Legs | □ Burning Pain | □ Pain in Legs w/ exercise |
| □ Throbbing/Cramping Pain | □ Skin Changes | □ Swelling (Legs or Ankles) |
| □ Skin Ulcers | □ Numbness | ¨Pain in Legs while resting |
| □ Itching | □ Tingling | □ Skin discoloration |
| □ Any symptoms NOT listedabove à |  |  |

1. Alleviating factors? (circle all that apply):

Sitting – Surgery – Rest - Weight loss – Elevation – Compression - OTC medication

1. How does it affect your daily life?
2. Have your veins become worse in the past several months?
3. Insurance requires 3 months of support hose use. Have you worn support hose?

If so, for how long?

1. Have you taken any analgesic medication for the pain?
2. Have you ever been treated for vein problems?

If yes, by whom, when and where:

1. Do you have a family history of vein symptoms (varicose veins, spider veins, leg ulcers, blood clots or swollen legs?)

a. If yes, who?

1. Do you have a personal history of the following? (Check all that apply)

|  |  |  |
| --- | --- | --- |
| □ Blood Clots/Phlebitis | □ Thyroid | □ High Blood Pressure |
| □ Diabetes | □ Asthma | □ Fainting/Dizziness |
| □ Stroke | □ Vascular Disease | □ Heart Disease |
| □ Seizures | □ Hepatitis | ¨Migraines/Headaches |

1. Do you have a family history of blood clots or phlebitis?
2. Please list all allergies:
3. List all medications that you are currently taking: (include birth control pills/hormones, blood thinners)
4. When was your last menstrual period?
5. Number of Pregnancies:
6. Do you use tobacco? (includes snuff, cigars, cigarettes, etc.)

Yes: How much:

Not Currently: When/How much?

Never

Do you use Alcohol? If so, How much and How often?

1. Please list all previous surgeries:

Patient Signature Date:

Physician Signature Date: