VeinSpecialists OF TAMPA

Patient Health History Form

Have you ever had any of the following:	Right	Left	Both	Neither	If so, When?
An injury to either of your legs that required an operation or casting?					
A deep vein thrombosis (D.V.T.). Also known as a blood clot in your leg?					
Phlebitis?					
A Venous Stasis Ulcer?					
Hemorrhage from a Varicose Vein?					
Sclerotherapy?					
Vein stripping?					

Please answer the following very carefully, as it will help your insurance company decide if your vein problems are a covered benefit. In the last six months have you . . . .

. . .tried support stocking to relieve your vein problems without success?	Yes	No	. . .had to take time off work because of your vein problems?	Yes	No
. . .had to take pain medicine because of your vein problems?	Yes	No	. . .had to limit your activities and lifestyle because of your vein problems?	Yes	No

Please indicate if you have any of the following conditions by circling Yes or No:

Diabetes	Yes	No	Seizures	Yes	No
Heart Disease	Yes	No	Renal Failure	Yes	No
Lung Disease	Yes	No	Hepatitis	Yes	No
Hypertension	Yes	No	HIV Infection	Yes	No
Arthritis	Yes	No	Fainting	Yes	No
Cancer	Yes	No	Tobacco Use	Yes	No

Please indicate (by circling Yes or No) if you currently (or recently) were on any of the following:

Coumadin/Pradaxa	Yes	No	Topical skin medications	Yes	No
Plavix	Yes	No	Antibiotics	Yes	No
Daily Aspirin	Yes	No	Steroids	Yes	No

For Women Only: Please indicate if Yes or No if you are . . .

Pregnant or think you might be?	Yes	No	Taking Oral Contraceptives?	Yes	No
Currently Nursing (Breast Feeding)?	Yes	No	On Hormone Replacement Therapy (HRT)?	Yes	No
Do you think you will have more children?	Yes	No	Do you anticipate starting HRT Soon?	Yes	No

How many times have you gone through childbirth?_____

Tell us what kind of work you do by completing the following sentence:

Patient Name:_____ Date:_____

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I work as a/an. . . . ._____
(If you are retired, tell us what kind of work you did before retirement and when you retired.)

In your own words, please describe the problem for which you are seeking our services:_____

_____

May we send a report of our findings, recommendations findings to your family doctor? ☐Yes ☐No

If so, please give us the name and phone number of your family doctor:_____
Name Phone#

Please list all medications that you take on a regular basis:

_____

_____

Are you allergic to anything? [ ]Yes [ ]No

If yes, please list any and all allergies:_____

_____

Family History: Please indicate if any of the following conditions were present in your immediate family members:

Varicose Veins?	Yes	No
Venous Ulcers?	Yes	No
Deep Vein Thrombosis?	Yes	No

Phlebitis?	Yes	No
A history of Vein Surgery?	Yes	No
Blood Clots?	Yes	No

Past Surgical History:

Have you ever had surgery? [ ]Yes [ ]No

If you have had surgery, what type and when?_____

_____

_____

Additional Medical History Not Mentioned Above:

Are you presently seeing another physician for anything NOT mentioned above? [ ]Yes [ ]No

If so, What is the Doctors Name?_____

If so, For what condition(s) is he or she treating you?_____

_____

Have you ever been hospitalized for anything NOT mentioned above? [ ]Yes [ ]No

If so, for what, at what Hospital, and when?_____

Review of Systems: Do you currently have any of the following?

If you check "Yes" for anything, explain on the line below the checkbox.

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No	Yes	
		Constitutional: (Fevers, chills, recent unexplained loss of appetite or weight).
		Eyes:(Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting).
		ENT: (No recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears).
		Cardiac: (No chest pain, shortness of breath, waking from sleep breathless, or cardiac meds).
		Respiratory: (No shortness of breath, productive cough, coughing up blood, or pain with breathing).
		Gastrointestinal: (No change in bowel habits, no black, red or bloody stools, vomiting or belly pain).
		Genitourinary: (No incontinence, frequent, urgent or painful urination. No waking at night to urinate).
		Musculoskeletal: (No change in walking ability or strength. No painful joints)
		Skin: (No problematic rashes or itching, no changes in skin color or sores that won't heal)
		Neurological: (No unexpected, unexplained numbness, tingling, or loss of memory or movement).
		Psychiatric: (No suicidal thoughts or hallucinations)

Patient Name:_____ Date:_____