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? | | | | | |

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

_____

Tell us what kind of work you do by completing the following sentence:
I work as a/an. . . . .
(If you are retired, tell us what kind of work you did before retirement and when you retired.)

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 | | | |

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

| | | | | | |
|---|---|---|---|---|---|
| Coumadin/Pradaxa/Eliquis/ or Xarelto | Yes | No | Topical skin medications | Yes | No |
| Plavix | Yes | No | Antibiotics | Yes | No |
| Daily Aspirin | Yes | No | Steroids | Yes | No |



Patient Name:_____

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

| | | |
|---|---|---|
| Pregnant or think you might be? | Yes | No |
| Currently Nursing (Breast Feeding)? | Yes | No |
| Do you think you will have more children? | Yes | No |

| | | |
|---|---|---|
| Taking Oral Contraceptives? | Yes | No |
| On Hormone Replacement Therapy (HRT)? | Yes | No |
| Do you anticipate starting HRT Soon? | Yes | No |

How many times have you gone through childbirth?_____

**Tobacco History:**
Please indicate your tobacco use history and frequency.

☐ Never ☐ Former user

☐ Use currently: (circle one) Packs/day: 1 2 3 other:_____

**Alcohol Use**:
Approximately _____ drinks per day / week

**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?_____



Patient Name:_____

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

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

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



Patient Name:_____

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# Patient Health History Form

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

| Drug Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

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

If yes, please list any and all allergies:

| Allergy | Severity | Reaction |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |



Patient Name:_____