The Venous Institute of Buffalo

Michael A. Vasquez, MD, FACS, RVT

Patient's Name _____ DOB _____ Date _____

HEALTH HISTORY FORM

Please answer the following questions in regards to your venous history.

Are you here today for how your legs look or how they feel? _____
How long have you had varicose veins or spider veins? _____
How long have you had leg vein symptoms? _____
Were your leg veins and/or symptoms present during pregnancy? _____
Do you have any family history of varicose veins, ulcers or clotting disorder? _____
Have you had any previous leg vein procedures or surgeries? If yes, please explain. _____
_____
Do you have a history of clotting disorder, phlebitis, bleeding from the vein? If yes, please explain.
_____
Have you ever had any testing done for clotting disorder? _____
Have you had an ultrasound or Doppler prior to your visit today? _____
Are you currently on hormone replacement therapy or birth control? _____
Have you worn prescription strength compression stockings? If yes, how long were they worn? _____
Did wearing compression stockings reduce your leg symptoms? _____
Have you had any major leg injury or surgery? _____
Do you take medication on a regular basis for your leg symptoms? (I.e. Tylenol, Ibuprofen) _____
Do you exercise regularly? _____
Have you had leg sores, ulcers or open wounds? _____

During the past week, how much of the time have you had the following leg problems?

(Check one box on each line)	All of the time		Most of the time		A good bit of the time		Some of the time		A little of the time		None of the time	
	R	L	R	L	R	L	R	L	R	L	R	L
a. Heavy legs												
b. Aching legs												
c. Swelling												
d. Night cramps												
e. Heat or burning sensation												
f. Restless legs												
g. Throbbing												
h. Itching												
i. Tingling sensation												

How much leg pain have you had during the past week? (check one for each leg)					
R	**L**		**R**	**L**	
		None			Moderate
		Very mild			Severe
		Mild			Very severe
Compared to one year ago, how is your leg problem now? (check one for each leg)					
R	**L**		**R**	**L**	
		Much better now			Somewhat worse now
		Somewhat better now			Much worse now
		About the same now			I did not have leg problems one year ago

Please check all that apply.

What factors make your symptoms worse?		**What factors make your symptoms better?**	
Prolonged standing	□	Elevating legs	□
Prolonged sitting	□	Rest/sleep	□
Prolonged walking	□	Rubbing/massage	□
Extreme temperature changes	□	Compression stockings	□
Hormonal changes	□	Exercise/stretching	□
Exercise	□	Changing positions	□
Nothing	□	Nothing	□

Please check all of the *activities of daily living* that are affected by your leg vein symptoms.

Climbing stairs	□	Car trips (>2 hours)	□
Exercising	□	Household chores	□
Yard work	□	Bending/kneeling	□
Short walks	□	Dressing	□
Long walks	□		
Bathing	□		

Please check any of the following medical conditions that apply to you.

AIDS/HIV □	Back Pain □	COPD □	Factor V □	Kidney Disease □
Anemia □	Bleeding disorder □	Depression □	GERD □	Migraines □
Anxiety □	Blood clots □	Diabetes □	Gout □	Miscarriage □
Arthritis □	Breast disease □	Eczema □	Heart disease □	Peptic Ulcer □
A-Fib □	Cancer □	Epilepsy □	Hepatitis B/C □	Spider veins □
				Varicose veins □

Allergies to medications and/or food:

_____
_____

Medications/Dosage (including non-prescription):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any other medical problems:

_____
_____
_____

Please list previous surgeries and dates if known:

_____
_____
_____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			

Patient's Social History

Marital Status:	Single ___	Married ___ Other ___
Alcohol Use:	Never ___	Rarely ___ Moderate ___ Daily ___
Tobacco Use:	Never ___	Previously, but quit ___ Date? ___ Current smoker/PPD? ___
Drug Use:	Never ___	Current user, type/frequency? _____

Patient's Height _____ Weight _____

Please check if you CURRENTLY have any of the following:

GENERAL
___Fever
___Chills
___Night sweats

EYES
___Vision loss in one eye

EARS/NOSE/THROAT
___Nose bleeds

CARDIOVASCULAR
___Difficulty breathing at night
___Chest pain or discomfort
___Racing/skipping heartbeat
___Shortness of breath with exertion
___Palpitations
___Difficulty breathing lying down
___Leg cramps with exertion
___Weight gain

RESPIRATORY
___Shortness of breath
___Coughing up blood
___Chest discomfort
___Wheezing

GENITOURINARY
___Blood in urine
___Pelvic pain

GASTROINTESTINAL
___Vomiting blood
___Nausea
___Vomiting
___Yellow skin color
___Dark, tarry stools
___Blood in the stools

MUSCULOSKELETAL
___ Joint pain
___ Joint swelling

DERMATOLOGICAL
___Suspicious lesions
___Dryness
___ Poor wound healing
___ Itching
___ Changes in skin color
___ Rash

NEUROLOGICAL
___ Headaches

PSYCHOLOGICAL
___ Anxiety
___ Depression

HEMATOLOGY
___ Abnormal bleeding
___ Abnormal bruising

Signature of Patient _____ **Date** _____

Signature of Physician _____ **Date** _____