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CONFIDENTIAL HEALTH HISTORY
PATIENT INFORMATION

PLEASE PRINT LEGIBLY.

Name: _____ Date: _____

Patient's DOB: _____ Patient's age: _____ Sex: []M []F
Family Physician: _____ City: _____
Referring Physician: _____ City: _____

PRESENT SYMPTOMS

Do your legs or ankles suffer from any of the following?:

- Pain? []Rt []Lt [____ : please rate on scale of 1-10, with 10 being worst]
□ Tingling? []Rt []Lt
□ Burning? []Rt []Lt
□ Numbness? []Rt []Lt
□ Aching? []Rt []Lt [____ : please rate on scale of 1-10, with 10 being worst]
□ Itchiness? []Rt []Lt
□ Pulsating/throbbing? []Rt []Lt
□ Tender to touch? []Rt []Lt
□ Restless legs? []Rt []Lt
□ Tiredness/fatigue? []Rt []Lt
□ Swelling? []Rt []Lt
□ Skin changes / discolorations? []Rt []Lt
□ Varicose veins / spider veins? []Rt []Lt
□ Bleeding from varicose veins? []Rt []Lt
□ Ulcerations? []Rt []Lt
□ Other? _____

When do you notice these symptoms?

- Standing □ During Evening □ Sitting □ Resting

When did you first notice these symptoms? _____

Have the symptoms become worse? Y / N If Yes, which symptoms have worsened? _____

For Female Patients:

Did pregnancy aggravate the symptoms? Y / N
Family history of still births? Y / N

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VENOUS MEDICAL HISTORY

Current Symptoms:

Do YOU have a history of: (please check all that are applicable)

- Deep Vein Thrombosis (DVT)
- Blood clot in the lungs
- Superficial Phlebitis
- Injuries to your leg(s) or veins
- Family history of varicose veins: Mother Father Grandparents
- Family history of deep venous thrombosis, stroke or clotting disorders
 - Mother Father Grandparents
- Occupation requiring long periods of standing / exertion
Occupation: _____

Treatment of Your Symptoms of Venous Disease:

Have you been treated for your veins before? Y / N

If YES, by whom? _____ When? _____

What method of treatment was used?

- Laser
- Radiofrequency Closure
- Sclerotherapy
- Stripping
- Other _____

What have your results been? _____

Have you worn Compression Medical Hose for conservative relief? Y / N If so, how long? _____

Are you on your feet for long periods? Y / N In what capacity? _____

Does walking/exercise relieve your discomfort or make it worse? Relieves Worsens

Do you have a history of any of the following: (please check all that are applicable)

- Varicose or Spider Vein treatment
- Venous ulcer treatment
- Bleeding from varicose veins
- Wearing compression stockings If YES, for how many months? _____
30-40mmHG. Compression stockings? Y / N If No, what mm? _____
- Taking anti-inflammatory medication for your legs
- Rest and elevation of legs to reduce your symptoms
- Exercise to reduce your symptoms If Yes, how many times per week? _____
- Weight loss to reduce your symptoms If Yes, # pounds _____ over # of years _____

For **FEMALE PATIENTS**:

- Currently pregnant
- Planning any future pregnancy
- Problem(s) during pregnancy. Please list: _____

PAST MEDICAL HISTORY (please check all that apply)

Do YOU have a history of:

- Kidney/Bladder Disease Liver Disease Hepatitis HIV/AIDS
- Diabetes; Insulin dependent Thyroid Disease Stroke
- Peripheral Vascular Disease TIA Coronary Heart Disease
- Heart Valve Problems Bleeding or Blood Disorder Anemia
- Pulmonary Embolus Easy Bruising High Blood Pressure Carotid Disease
- Atherosclerosis Rupture of a vein Trauma to your legs
- Blood Transfusion(Date) _____
- Cancer of _____
- Other: _____

Do you have any allergies or sensitivities to medicines or tape? List all: _____

PAST SURGICAL HISTORY (Include year of procedure) (attach additional sheet if necessary)

BLEEDING HISTORY (Please check all that apply)

- Excessive Bleeding Easy Bruising Aspirin Use
- Coumadin Use
- Other: _____

SOCIAL HISTORY (Please check all that apply)

- Smoke ____ packs per day for ____ years
- Alcohol use: ____ None ____ Social ____ # years

Occupation: _____

Marital Status: Married Single Divorced Widowed

Children(Ages –if under age 25): _____

FAMILY HISTORY (Please check all that apply)

- Family history of *heart disease*: Mother Father Grandparents Sibling
- Family history of *hypertension*: Mother Father Grandparents Sibling
- Family history of *diabetes*: Mother Father Grandparents Sibling

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- Family history of *cancer*: Mother Father Grandparents Sibling
 Family history of *strokes*: Mother Father Grandparents Sibling

CURRENT MEDICAL INFORMATION

Are you being treated for any current medical conditions? Y / N If so, what are these conditions? (attach separate sheet if necessary)

Please list all medicines that you take (Prescription, Non-Prescription Vitamins and Herbal):

REVIEW OF SYSTEMS (Please Check all that apply)

- Constitution:** Weight loss Weight gain Night sweats Fever
Skin: Change in size/color of moles Rash Bruising
Eyes: Decreased vision Double vision Blurred vision Glasses
ENMT: Pain Deafness Discharge Ringing in ears Sinus drainage
 Nose bleed Hoarseness
Cardiac: Palpitations Chest pain Shortness of breath Fatigue Swelling in feet/legs
Respiratory: Cough Production of sputum Coughing of blood Pain
Gastro: Painful swallowing Nausea Vomiting Vomit blood Indigestion
 Diarrhea Constipation Tarry stools Yellow jaundice Bloody stools
 Change in BMs
Genito: Kidney/bladder disease Decreased urine stream
 Unable to urinate Painful urination Blood in urine
Musc/Skel: Weakness Trauma Limited motion Bone/joint deformity
Neuro: Paralysis Weakness Seizure Fainting
 Headache Migraine Incoordination Head trauma
 Numbness/tingling in extremities
Psych: Anxiety Depression Hallucinations
Endocrine: Change of appetite Excessive thirst/urination Goiter
Hemato: Swollen lymph nodes Bleeding disorders
Immuno: Immune disorders Immunosuppression

[FEMALES ONLY:]

- Breast: Lumps Pain Nipple discharge Infection
 Trauma Last mammogram(date) _____
Gyn: Irregular periods Hormone therapy Menopause
 Last pelvic exam (date) _____ Last period(date)

Signature: _____ **Date:** _____