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| **Manu B. Aggarwal, M.D.**  **MEDICAL HISTORY**  **VENOUS/LYMPHEDEMA**  All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions must be answered. Failure to do so will result in an inaccurate medical record and may affect your insurance processing. PLEASE ASK if you have any questions. | | | | | | | | | | |
| Today’s Date: | | | | |  | 🞎 M 🞎 F | | Your Birthdate: | |  |
| Name (Last, First, M.I.): | | | | |  | |  | Age: | |  |
| **Pharmacy Name:** | | | **Pharmacy Street and City:** | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | |
| Medical problems that other doctors have diagnosed: 🞎 Yes 🞎 No (Check No if no current medical problems) | | | | | | | | | | |
| 🞎 Diabetes | | 🞎 Seizures | | | 🞎 Cancer (what kind\_\_\_\_\_\_\_\_\_\_\_ 🞎 On chemotherapy | | | | | |
| 🞎 Kidney Failure | | 🞎 lung disease | | | 🞎 Heart Disease 🞎 Hole in heart | | | | | |
| 🞎 DVT/SVT (blood clot in veins) | | 🞎 HIV | | | 🞎 Hepatitis 🞎 Migraines | | | | | |
| 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Arthritis | | | | | | | | | | |
| Additional History for Women ONLY: | | | | | | | | | | |
| Are you nursing? 🞎 Yes 🞎 No | | | | How many vaginal deliveries? #\_\_\_\_\_ How many C-sections? #\_\_\_\_\_ | | | | | | |
| Do you plan on having more children? 🞎 Yes 🞎 No | | | | Did you ever have a DVT during pregnancy? 🞎 Yes 🞎 No | | | | | | |
| Are you pregnant? ? 🞎 Yes 🞎 NoIF YES: circle trimester: 1st  OR 2nd OR 3rd | | | | Do you take Hormone Replacement Therapy (HRT)? 🞎 Yes 🞎 NoIf you don’t take HRT now, have you in the past? 🞎 Yes 🞎 No | | | | | | |
| How many pregnancies have you had: #\_\_\_\_\_ | | | | Do you take birth control pills (OCPs)? 🞎 Yes 🞎 NoIf you don’t take OCPs now, have you in the past? 🞎 Yes 🞎 No | | | | | | |
| Which, if any gynecological surgeries: (circle all that apply please): None, Fibroids, Endometriosis, C-section, Hysterectomy, Ovary Removal, Ovarian cysts, Myomectomy, Uterine Ablation | | | | | | | | | | |
| Surgeries: | | | | | | | | | | |
| Year | Surgery | | | | Year ( if more continue here) | | | | Surgery ( if more, continue here) | |
|  |  | | | |  | | | |  | |
|  |  | | | |  | | | |  | |
|  |  | | | |  | | | |  | |
| **YOUR Vein History:** | | | | | | | | | | |
| Have you had a DVT in the **RIGHT** leg? 🞎 Yes 🞎 No  What year was the DVT found? \_\_\_\_\_\_  If YES for DVT: do you know if it was from surgery? 🞎 Yes 🞎 No  If not from surgery, was it from traveling? 🞎 Yes 🞎 No  Was the cause of your DVT ever figured out? 🞎 Yes 🞎 No  Was the DVT (circle one) : BELOW THE KNEE or ABOVE THE KNEE  Did you have the DVT treated at the hospital? 🞎 Yes 🞎 No IF YES, did you have thrombolysis OR thrombectomy? (circle one)  If you have treatment for your DVT, what medication did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Have you had a DVT in the **LEFT** leg? 🞎 Yes 🞎 No  What year was the DVT found? \_\_\_\_\_\_\_  If YES for DVT: do you know if it was from surgery? 🞎 Yes 🞎 No  If not from surgery, was it from traveling? 🞎 Yes 🞎 No  Was the cause of your DVT ever figured out? 🞎 Yes 🞎 No  Was the DVT (circle one) : BELOW THE KNEE or ABOVE THE KNEE  Did you have the DVT treated at the hospital? 🞎 Yes 🞎 No IF YES, did you have thrombolysis OR thrombectomy? (circle one)  If you have treatment for your DVT, what medication did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Are you currently taking a blood thinner? 🞎 Yes 🞎 No IF YES, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How long have you been taking this blood thinner? \_\_\_\_\_\_\_\_weeks \_\_\_\_\_\_\_\_\_\_\_\_months \_\_\_\_\_\_\_\_\_\_\_\_years  Have you had surgery less than 3 months ago? 🞎 Yes 🞎 No  Have you been immobile less than 3 months? 🞎 Yes 🞎 No  Have you been diagnosed with Pelvic Venous Congestion? 🞎 Yes 🞎 No | | | | | | | | | | |
| Have you had PHLEBITIS in the **RIGHT** leg?  # of times you had phlebitis in the **RIGHT** leg \_\_\_\_\_\_  What year(s) did you have Phlebitis in the **RIGHT** leg? \_\_\_\_\_\_\_\_\_ | | | | | Have you had PHLEBITIS in the **LEFT** leg?  # of times you had phlebitis in the **LEFT** leg \_\_\_\_\_\_  What year(s) did you have **LEFT** Phlebitis? \_\_\_\_\_\_\_\_\_ | | | | | |
| Have you ever broken your **RIGHT** LEG?  If yes, how many times? #\_\_\_\_\_\_  If yes, was it (circle all that apply): below knee above knee pelvis  If yes how was your leg treated? (circle all that apply)  Support bandages, Casted, Pin/plates, other Surgery | | | | | Have you ever broken your **LEFT**  LEG?  If yes, how many times? #\_\_\_\_\_\_  If yes, was it (circle all that apply): below knee above knee pelvis  If yes how was your leg treated? (circle all that apply)  Support bandages, Casted, Pin/plates, other Surgery | | | | | |
|  |  | | | |  | | | | | |
| **Family History** Do you have a family history of the following conditions? 🞎 Yes 🞎 No 🞎 Unknown | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **If yes, please check appropriate box:** | Mother | Father | Brother | Sister | Other | | Varicose veins (bulging veins) |  |  |  |  |  | | DVT (blood clot in deep veins) |  |  |  |  |  | | Blood disorder (hemophilia, VonWillebrand) |  |  |  |  |  | | Clotting disorder (Factor V, miscarriages, MTHFR) |  |  |  |  |  | | Lymphedema |  |  |  |  |  | | Other |  |  |  |  |  | | | | | | | | | | | |
| **Social History** | | | | | | | | | | |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retired: 🞎 Yes 🞎 No | | | | | | | | | | |
| Do you drink alcohol? 🞎 Yes 🞎 No If yes, How many times in the past year have you had >4 drinks in one day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Do you smoke? 🞎 Yes 🞎 No **If yes, do you smoke:** 🞎 **less than 9 cig/day** 🞎 **greater than 10 cig/day** 🞎**use chewing tobacco**  If yes, please answer below: If you answered No and are a former smoker:  \*At what age did you start? \_\_\_\_ How long did you smoke? \_\_\_\_  \*How many packs per day do you smoke? \_\_\_\_ At what age did you start? \_\_\_\_  \*Have you ever thought about quitting? 🞎 Yes 🞎 No How many packs per day did you smoke? \_\_\_\_  \*Are you ready to quit? 🞎 Yes 🞎 No Why did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Are you: 🞎 Married 🞎 Unmarried 🞎 Divorced 🞎 Widowed How many children do you have?\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **MEDICATIONS**  Are you currently taking any medications – prescription, over the counter, or vitamins/supplements? 🞎 Yes 🞎 No | | | | | | |
| List your medications | | | | | | |
| Name the Drug | | Strength | Frequency Taken | Name the Drug | Strength | Frequency Taken |
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|  | |  |  |  |  |  |
| Allergies | Do you have any allergies (Medication, food, other)? 🞎 Yes 🞎 No  Please list and briefly describe your reaction. (i.e. rash, hives, shortness of breath, etc) | | | | | |
| Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severity (Circle): Mild Moderate Severe  Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severity (Circle): Mild Moderate Severe | | | | | |

**Do you have any of the following symptoms? Place an X in the box.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Right Leg** | **Left Leg** | **Both** |
| **Aching (if yes, where?)** |  |  |  |
| **Do your symptoms awake you at night?** |  |  |  |
| **Bleeding of a vein?** |  |  |  |
| **Burning?** |  |  |  |
| **Cramping?** |  |  |  |
| **Difficulty healing wounds?** |  |  |  |
| **Fatigue (tired) legs?** |  |  |  |
| **Heaviness in legs?** |  |  |  |
| **Itching?** |  |  |  |
| **Restless legs?** |  |  |  |
| **Swelling?** |  |  |  |
| **Ulcers? (open wounds on legs)** |  |  |  |
| **Varicose (bulging) veins?** |  |  |  |
| **Spider veins?** |  |  |  |
| **Skin discoloration?** |  |  |  |
| **Pelvic pain?**  **If yes, circle what symptoms: heaviness in pelvis pain with intercourse** |  |  |  |

**Please use diagrams below to mark where you feel your symptoms.**





**INNER**

**BACK**

**FRONT**

Right Left Left Right Right Left

|  |  |
| --- | --- |
| Please rate the severity of your pain (Scale 0-10 with 10 being the worst pain)? | RIGHT: \_\_\_\_\_\_\_\_\_\_(0-10) LEFT:\_\_\_\_\_\_\_\_\_\_(0-10) |
| How long have you noticed your leg symptoms? NUMBER OF: | Days\_\_\_\_\_\_\_ Months\_\_\_\_\_\_\_\_\_ Years\_\_\_\_\_\_\_\_\_\_ |
| If you have an ULCER (open sore), how long have you had it? | Days\_\_\_\_\_\_\_ Months\_\_\_\_\_\_\_\_\_ Years\_\_\_\_\_\_\_\_\_\_ |
| When are your symptoms ? | **🞎 nighttime 🞎 daytime 🞎 all day** |
| Which leg is worse? | **Right \_\_\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_\_\_\_\_\_ Both about the same\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| How do your symptoms affect your life? | **🞎 At work? 🞎 During daily chores? 🞎 During caring for family? 🞎 During traveling?** |
| Your symptoms are made WORSE by: | **🞎 prolonged standing 🞎 heat**  **🞎 prolonged sitting 🞎 menstrual cycle**  **🞎 leg elevation 🞎 pregnancy**  **🞎 walking 🞎 travel**  **🞎 exercise** |
| Your symptoms are made BETTER by: | **🞎 leg elevation 🞎 heat**  **🞎 prolonged standing 🞎 menstrual cycle**  **🞎 prolonged sitting 🞎 pregnancy**  **🞎 walking 🞎 travel**  **🞎 exercise** |

Notes/Additional Symptoms:

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever done any of the following:** | **YES** | **NO** | **IF YES for compression stockings**  **(circle how often and tell us for how long please)** |
| **Wear compression stockings or compression bandages?** |  |  | **Intermittent Most Days Fully Compliant(Daily)**  **\_\_\_\_\_\_weeks \_\_\_\_\_months \_\_\_\_\_years** |
| **Elevate your legs at end of day?** |  |  |
| **Exercise/walking?** |  |  |
| **Lost weight to try to make legs feel better?** |  |  |
| **Avoid prolonged standing or sitting?** |  |  |
| **Cold/warm soaks?** |  |  |
| **Compression pumps?** |  |  |
| **Lymphedema therapy?** |  |  |
| **Taken medication to help with leg pain?** |  |  | **Name of Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| --- |
| Review of systems |
| **Do you currently have any of the following?**  **If you circle any, THIS indicatES “Yes”**   |  | | --- | | **Constitutional:** fatigue, fevers, chills, recent unexplained loss of appetite or weight | | **Eyes:** any recent unexplained change in visual acuity, double vision, excessive tearing or crusting | | **ENT (ear, nose throat):** cold sores, hoarse voice, sinus problems, discharge, sore throat | | **Cardiac:** any chest pain, palpitations, shortness of breath with walking, waking from sleep breathless, swelling in legs, varicose veins | | **Respiratory:** cough, coughing up blood, or wheezing | | **GASTROINTESTINAL:** abdominal pain, black or red or bloody stools, difficulty swallowing, heartburn, hemorrhoids, jaundice, pain with bowel movements, rectal bleeding, vomiting blood | | **Genitourinary: male**: enlarged prostate, infection of penis or prostate or testicle, impotence  **female:** labial veins, buttock bulging veins | | **Musculoskeletal:** ankle pain, back pain, foot pain, hip pain, knee pain, leg cramps | | **Skin**: easy bruising, eczema, hair loss, heavy sweating, itching, rashes, skin lesions, ulcers (sores) | | **Neurological**: difficulty speaking, numbness, dizzy, drooping of face, frequent headaches, fainting spells, involuntary movements, leg weakness, migraines, needle phobia, nervousness | | **Psychiatric:** anxiety, depression, insomnia, mood swings | | **ENDOCRINE:** cold intolerance, excessive thirst, heat intolerance, incontinent | | **HEME/LYMPH:** bleeding tendencies, enlarged lymph nodes | | **ALLERGY/IMMUNOLOGY::** hives, itching, rashes, recurrent infections | |

Thank you for providing this important information about your medical history. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Aggarwal will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_