Vein Care Center
Laser Specialists

Venous and Lymphatic Medical History

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.

Date: ____/_____/_____

Your Name: (Last, First, MI)_____ Date of Birth:___/____/_____ Age: _____

How do you identify yourself: (Place an "X") Male_____ Female _____ Other_____

Pharmacy – Name: _____ Location: _____

PLEASE CIRCLE BELOW ALL MEDICAL DIAGNOSES YOU HAVE:

PAST MEDICAL HISTORY				
Diabetes	Heart Disease/Congestive Heart Failure	Hepatitis/Liver Disease	Hypertension (high blood pressure	Kidney Disease
Migraines	Lung Disease	B12 deficiency	Restless Legs	HIV
Arterial Disease	Stroke	Cancer	Hole in your heart (Patent Foramen Ovale)	Pacemaker
Anemia	Lymphedema	Asthma	Arthritis	OTHER:_____ _____

PLEASE CIRCLE THE ANSWER THAT FITS YOU – FEMALES ONLY:

PAST MEDICAL HISTORY: PREGNANCY/NURSING HISTORY						
QUESTION	**ANSWERS**					
1. Are you nursing?	Yes	No				
2. Are you planning more children?	Yes	No				
3. Are you Pregnant?	Yes	No	**If yes, which Trimester?**	First	Second	Third
4. How many pregnancies have you had?	#_____	**How many C-sections?**	**#_____**	**How many Vaginal Deliveries?**	**#_____**	
5. Have you had a blood clot from pregnancy?	Yes	No				

6. Are you taking birth control pills?	Yes	No	**If no, have you taken them in the past?**	Yes	No	
7. Are you taking Hormone Replacement Therapy?	Yes	No	**If no, have you taken them in the past?**	Yes	No	

PLEASE CIRCLE ALL THE CONDITIONS/SURGERIES YOU HAVE HAD (FEMALE CONTINUED):

Fibroids	Endometriosis	C-Section	Hysterectomy	Ovary Removal
Ovarian Cysts	Myomectomy	Uterine Ablation	OTHER: _____	

PLEASE CIRCLE THE ANSWER THAT FITS YOU:

PAST VEIN HISTORY			
QUESTION	**ANSWER**		
1. Have you had a blood clot in the legs?	Yes	No	**WHAT YEAR? _____**
2. If YES, was the DVT from surgery?	Yes	No	I don't know
3. If YES, was the DVT from traveling?	Yes	No	I don't know
4. What was the cause of the DVT?			
5. Was the DVT below the knee?	Yes	No	I don't know
6. Was the DVT above the knee?	Yes	No	I don't know
7. Was the DVT in the pelvis?	Yes	No	I don't know
8. If your DVT was treated at hospital:	I had the clot removed (thrombectomy)	I had the clot broken up (thrombolysis)	I don' know
9. I was treated with medication for my DVT. The medication was:	**Name of medication: _____** **I took the medication for how long? _____**		I don't know
10. Are you currently taking a blood thinner?	Yes	No	**Name of the blood thinner: _____**
11. If you are taking a blood thinner, how long have you been on it?	_____Weeks	_____Months	_____Years

12. Have you had surgery in the last 3 months?	Yes	No	
13. Have you been immobile in the last 3 months?	Yes	No	
14. Have you been diagnosed with Pelvic Venous Congestion (pelvis)?	Yes	No	

PAST VEIN HISTORY – RIGHT LEG			
1. Have you had phlebitis in the RIGHT leg?	Yes	No	**What year(s)? _____ How many times?_____**
2. Have you broken your RIGHT leg? If yes, how many times?	#_____ of times		
3. If you have broken your RIGHT leg, the break was located:	Above the Knee	Below the Knee	Pelvis
4. If you had your broken RIGHT leg treated, it was:	Bandaged	Casted	Pins/plates

PAST VEIN HISTORY – LEFT LEG			
QUESTION	**ANSWER**		
1. Have you had phlebitis in the LEFT leg?	Yes	No	**What year(s)? _____ How many times?_____**
2. Have you broken your LEFT leg? If yes, how many times?	#_____ of times		
3. If you have broken your LEFT leg, the break was located:	Above the Knee	Below the Knee	Pelvis
4. If you had your broken LEFT leg treated, it was:	Bandaged	Casted	Pins/plates

PAST SURGERIES – NON VEIN	
SURGERY	**YEAR**

PAST VEIN SURGERIES	
SURGERY (STRIPPING, LASER, ETC.)	**YEAR**

PLEASE PLACE AN "X" IN THE ANSWER THAT FITS YOUR FAMILY:

FAMILY HISTORY FOR VENOUS DISEASES					
CONDITION	**MOTHER**	**FATHER**	**BROTHER**	**SISTER**	**OTHER FAMILY**
Varicose veins (bulging veins)					
Blood clots					
Blood disorder (hemophilia, Von Willdebrand)					
Clotting disorder (Factor V, miscarriages)					
Lymphedema					

PLEASE FILL IN THE BLANKS AND CIRCLE THE ANSWER THAT FITS YOU:

SOCIAL HISTORY					
1. OCCUPATION:					
2. Are you retired?	Yes	No			
3. Do you drink alcohol?	Yes	No	**If yes, how many times have you had more than 4 drinks in one day in the past year?**	_____# of times more than 4 drinks in one day	
4. Do you smoke?	Yes	No	**If yes, do you smoke: (circle)**	less than 9 cig/day	Greater than 10 cig/day
5. Do you use chewing tobacco?	Yes	No			
6. If you smoke:	**What age did you start? age_____**	**How many packs per day? ____packs/day**	**Have you thought about quitting?**	Yes	No
7. If you are a FORMER Smoker:	**How long did you smoke? _____years**	**At what age did you start? age____**	**How packs per day? ___packs/day**		
8. Marital Status?	Married	Unmarried	Divorced	Widowed	Other_____
9. Do you have children?	Yes	No	**If yes, how many children? _____**		

CURRENT MEDICATIONS (please include all over the counter and supplements)		
Name	**Strength**	**Frequency (how often)**

ALLERGIES		
Medication/Food	**Type of reaction (rash, hives, etc.)**	**CIRCLE severity of reaction**
		mild moderate severe
		mild moderate severe
		mild moderate severe
		mild moderate severe

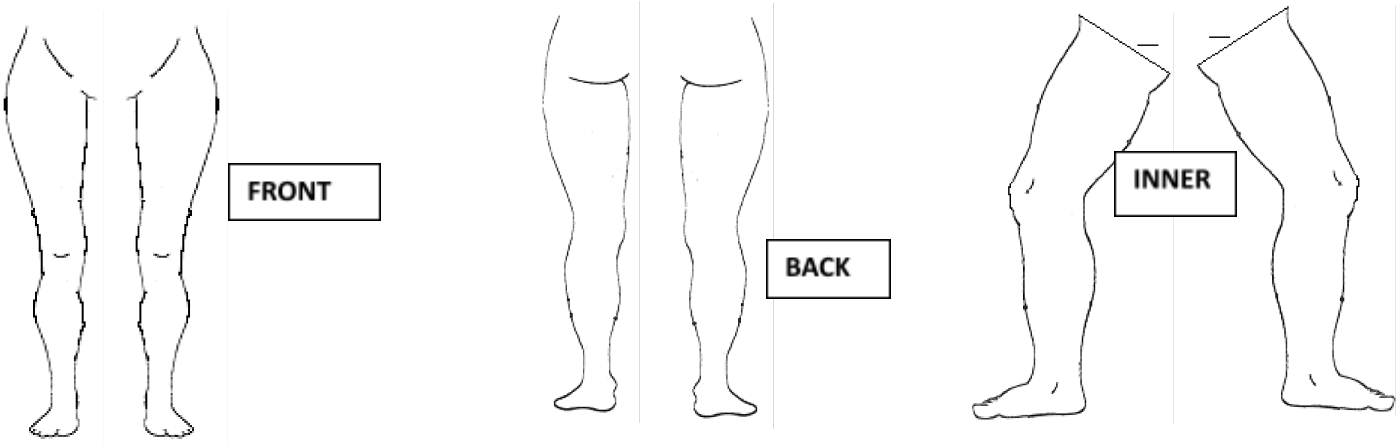
PLEASE MARK WITH AN "X" UNDER THE CORRECT LOCATION OF YOUR SYMPTOMS:

CC/HPI SYMPTOMS			
SYMPTOM	**RIGHT LEG**	**LEFT LEG**	**BOTH LEGS**
Aching			
Awakened at night			
Bleeding from veins			
Burning			
Cramping			
Difficulty healing			
Fatigue			
Heaviness			
Itching			
Pain			
Restless Legs			
Swelling			
Ulcers	For how long on the RIGHT? (circle one) Less than 3 months 4-11 months Over 12 months	For how long on the LEFT? (circle one) Less than 3 months 4-11 months Over 12 months	
Varicose veins			
Spider veins			
Skin Discoloration			

Tenderness			

PELVIC PAIN SYMPTOMS			
Symptom	**Yes**	**NO**	**NOTES**
Pelvic pain and varicose veins			
Achiness and heaviness in pelvis			
Deep pain with intercourse			
Hip pain			
Back pain			
Lower abdominal pain			
Pain during menstrual cycle			

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



Right Left Left Right Right Left

PLEASE MARK AN "X" FOR YOUR LEG SYMPTOMS:

SEVERITY OF SYMPTOMS		
SEVERITY	**RIGHT LEG**	**LEFT LEG**
MILD		
MODERATE		
SEVERE		

How long have you had your symptoms? _____days _____months _____years
When do your symptoms bother you the most? ____daytime ____nighttime _____all day _____while lying down/bedtime
Which leg is worse? ____right or ____left
Your symptoms affect you at: ____work ___daily chores at home ___caring for family ____during traveling

PLEASE CIRCLE AND FILL IN BLANKS THAT MATCHES YOUR SYMPTOMS:

SYMPTOMS ARE WORSE AND BETTER/AGGRAVATING AND ALLEVIATING FACTORS									
Symptoms are **WORSE** when	Prolonged standing	Prolonged sitting	Leg elevation	Walking	Exercise	Heat	Menstrual cycle	Pregnancy	Travel
Symptoms are **BETTER** when:	# breaks sitting___ # breaks standing___	Leg elevation	Standing	Sitting	Walking	Exercise	Heat	Pregnancy	Travel

CONSERVATIVE THERAPY HISTORY		
CONSERVATIVE TREATMENT	**YES**	**NO**
Have you worn compression stockings?	If yes, for how long? ____days ____months _____years If yes, do you wear them: ___intermittently ___daily ____everyday	No
Do you elevate your legs to make them feel better?	Yes	No
Have you tried exercise to make your legs feel better?	Yes	No
Have you tried to lose weight to make your legs feel better?	Yes	No
Have you avoided prolonged standing or sitting to make your legs feel better?	Yes	No
Have you tried cold or warm soaks?	Yes	No
Have you tried compression pumps?	Yes	No
Have you tried lymphedema therapy?	Yes	No
Have you tried medication?	If yes, which medication: _____	

PLEASE CIRCLE THE ANSWER THAT FITS YOU:

REVIEW OF SYSTEMS: PLEASE CIRCLE ANY THAT APPLY TO YOU. CIRCLING INDICATES "YES".

CONSTIUTIONAL	Fatigue, chills, recent unexplained weight loss
CARDIAC	Chest pain, palpitations, shortness of breath with walking, waking from sleep breathless, swelling in legs, varicose veins
RESPIRATORY	Cough, coughing up blood, or wheezing
GI	Abdominal pain, black or red or bloody stools, difficulty swallowing, heartburn, hemorrhoids, jaundice, pain with bowel movements, rectal bleeding, vomiting blood
GU	**male**: enlarged prostate, infection of penis or prostate or testicle, impotence **female:** labial veins, buttock bulging veins
MSK	ankle pain, back pain, foot pain, hip pain, knee pain, leg cramps
INTEGUMENTARY	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

Notes/Additional Symptoms:

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 and the staff 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): _____

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First Name:_____ Last Name: _____ M. Initial: _____

Date of Birth:_____ Sex:_____ S.S#:_____

Address:_____ City: _____ State:_____ Zip: _____

Marital Status: _____ Email: _____ Employer: _____

Home Phone:_____ Cell Phone:_____

Race*: □Am. Indian □Asian □African American □White □Decline to Answer □ Other

Ethnicity: □Hispanic or Latino □ Not Hispanic or Latino □Decline to Answer **Language:**_____

Primary Insurance:_____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth:_____ Policy Holder Date of Birth:_____

Do you have a co-pay □Yes □No If yes, Co-pay Amount:_____

Family Physician: _____ How did you hear about us?:_____

I hereby acknowledge that on _____ (date) I have reviewed the Notice of Privacy Practice and Financial Policy of Vein Care Center which sets for the ways in which my personal health information may be used or disclosed by Vein Care Center and acknowledges that I am financially responsible for payment of any balances due.

You may disclose my health information to any of the following persons (Ex: Doctors, Family, Employer, etc.):

_____

The full copy of the Vein Care Center's Privacy Notice and financial policy are kept in the office. You may ask to review the full policies at any time.

Emergency Contact:_____ Phone: _____ Relationship: _____

I hereby do ____do not ____ give permission to The Vein Care Center to photograph the areas I would like treated, both before and after treatment. I understand these photographs will be used to monitor the progress of my treatments. I understand that if used for marketing or medical research purposes these photographs will not contain my name or other identifying information. I understand that I will not be entitled to any payment or other form of renumeration as a result of any use of the photographs.
I have read and fully understand and agree to the HIPAA, Financial and photography policies of this practice.

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Patient Signature: _____ **Date:** _____