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**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 |  |
| 1. **Are you planning more children?**
 | Yes  | No |  |
| 1. **Are you Pregnant?**
 | Yes | No | **If yes, which Trimester?** | First | Second | Third  |
| 1. **How many pregnancies have you had?**
 | #\_\_\_\_\_\_\_\_ | **How many C-sections?** | **#\_\_\_\_\_\_\_\_** | **How many Vaginal Deliveries?** | **#\_\_\_\_\_\_\_** |  |
| 1. **Have you had a blood clot from pregnancy?**
 | Yes | No  |  |  |  |  |
| 1. **Are you taking birth control pills?**
 | Yes | No | **If no, have you taken them in the past?**  | Yes | No |  |
| 1. **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? \_\_\_\_\_\_\_\_** |
| 1. **If YES, was the DVT from surgery?**
 | Yes | No  | I don’t know |
| 1. **If YES, was the DVT from traveling?**
 | Yes | No | I don’t know |
| 1. **What was the cause of the DVT?**
 |  |
| 1. **Was the DVT below the knee?**
 | Yes | No | I don’t know |
| 1. **Was the DVT above the knee?**
 | Yes | No |  I don’t know |
| 1. **Was the DVT in the pelvis?**
 | Yes | No | I don’t know |
| 1. **If your DVT was treated at hospital:**
 | I had the clot removed (thrombectomy) | I had the clot broken up (thrombolysis) | I don’ know  |
| 1. **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  |
| 1. **Are you currently taking a blood thinner?**
 | Yes | No | **Name of the blood thinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **If you are taking a blood thinner, how long have you been on it?**
 | \_\_\_\_\_\_\_Weeks | \_\_\_\_\_\_\_Months | \_\_\_\_\_\_Years |
| 1. **Have you had surgery in the last 3 months?**
 | Yes  | No |  |
| 1. **Have you been immobile in the last 3 months?**
 | Yes | No |  |
| 1. **Have you been diagnosed with Pelvic Venous Congestion (pelvis)?**
 | Yes | No |  |

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

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|  **PAST SURGERIES – NON VEIN** |
| **SURGERY** | **YEAR** |
|  |  |
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|  |  |
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|  |  |
|  **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:**
 |  |
| 1. **Are you retired?**
 | Yes | No  |  |
| 1. **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 |  |
| 1. **Do you smoke?**
 | Yes | No | **If yes, do you smoke: (circle)** | less than 9 cig/day | Greater than 10 cig/day |
| 1. **Do you use chewing tobacco?**
 | Yes | No |  |  |  |
| 1. **If you smoke:**
 | **What age did you start?** **age\_\_\_\_\_\_** | **How many packs per day? \_\_\_\_packs/day** | **Have you thought about quitting?**  | Yes  | No |
| 1. **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** |  |  |
| 1. **Marital Status?**
 | Married  | Unmarried | Divorced  | Widowed | Other\_\_\_\_\_\_\_\_ |
| 1. **Do you have children?**
 | Yes | No  | **If yes, how many children? \_\_\_\_\_\_\_** |  |  |

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| **CURRENT MEDICATIONS (please include all over the counter and supplements)** |
| **Name** | **Strength** | **Frequency (how often)** |
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| **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 months4-11 months Over 12 months | For how long on the LEFT? (circle one)Less than 3 months4-11 months Over 12 months |  |
| **Varicose veins** |  |  |  |
| **Spider veins** |  |  |  |
| **Skin Discoloration**  |  |  |  |
| **Tenderness** |  |  |  |

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| **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.**



  

**FRONT**

**BACK**

**INNER**

 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 \_\_\_\_\_yearsIf 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_