



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: ___/___/___

Circle how you identify yourself: Male Female Other

Pharmacy: _____ Location: _____

PLEASE CIRCLE MEDICAL DIAGNOSES YOU HAVE:

PAST MEDICAL HISTORY					
Anemia	Arterial Disease	Arthritis	Asthma	B12 Deficiency	Blood Clot Ever been on blood thinner? Yes or No
Cancer of: _____	Diabetes	Heart Disease/Congestive Heart Failure	Hepatitis/Liver Disease	HIV	Hole in Heart
Hypertension	Kidney Disease	Lung Disease	Lymphedema	MEN2	Migraines
Pacemaker	Papillary Thyroid Cancer	Pelvic Congestion Syndrome	Restless Legs	Stroke	OTHER: _____

FEMALES ONLY PLEASE CIRCLE THE ANSWER THAT FITS YOU:

PAST MEDICAL PREGNANCY 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	

FEMALES ONLY PLEASE CIRCLE ALL THE CONDITIONS/SURGERIES YOU HAVE HAD:

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

PAST SURGERIES	
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)					
Leg Ulcers					
Blood Clots					
Pulmonary Embolism					
Blood disorder (hemophilia, Von Willebrand)					
Clotting disorder (Factor V, miscarriages)					
Lymphedema					

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

SOCIAL HISTORY					
1. OCCUPATION (current or pre-retirement):					
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)

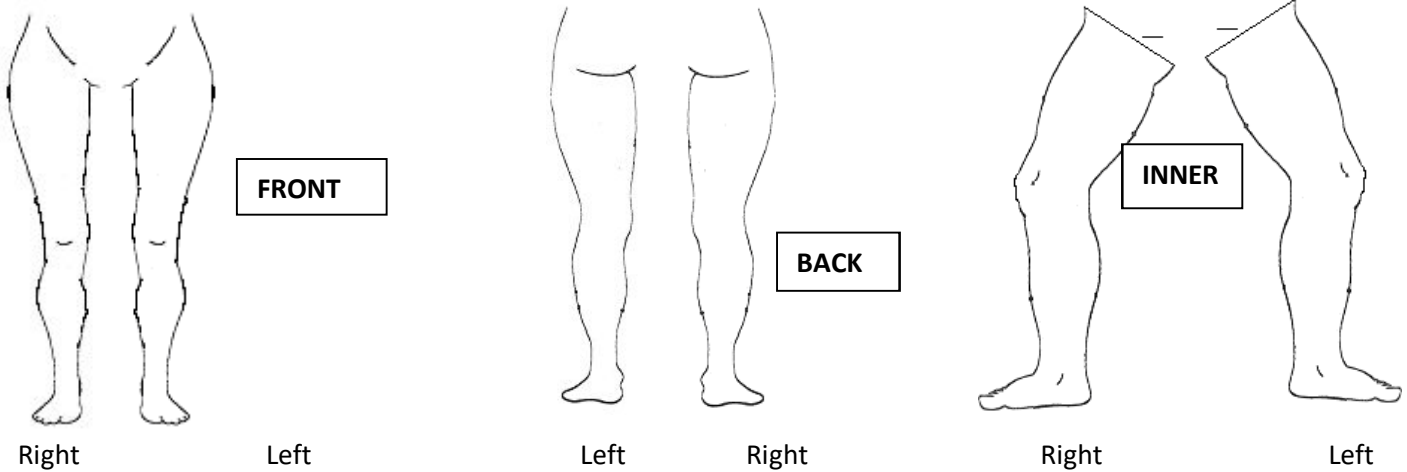
ALLERGIES No Known Allergies <input type="checkbox"/>		
Medication/Food	Type of reaction (rash, hives, etc.)	CIRCLE severity of reaction
		low moderate severe
		low moderate severe
		low moderate severe
		low moderate severe

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

CC/HPI SYMPTOMS		
SYMPTOM	RIGHT LEG	LEFT LEG
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			
Pain during menstrual cycle			

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



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:	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".	
CONSTITUTIONAL	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

IF INTERESTED IN WEIGHT LOSS, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

	YES	NO
Do you ever feel like your eating patterns can get out of control?		
Do you eat in between meals?		
Do you have any dietary restrictions?	If yes, which restrictions? _____ _____	
Do you currently have a physical activity routine?		
Have you been on a weight loss medication in the past?	If yes, which medication? _____ _____	
Are you currently on a weight loss medication?	If yes, which medication? _____ _____	
Do you have a gym membership?		
Do you have a therapist?	If yes, which type of therapist? _____ _____	

PLEASE CIRCLE ALL THAT APPLIES:

What type of physical activity do you participate in:

- a. Walking
- b. Aerobics Class/Exercise
- c. Weight Training
- d. Running
- e. Nothing

How long does the physical activity last:

- a. 30 min
- b. Greater than 30 minutes
- c. Less than 30 minutes

How often do you participate in physical activity:

- a. Daily
- b. 3 times a week
- c. 5 times a week
- d. Greater than 5 times a week

How many weight loss attempts have you tried in the past 5 years:

- a. 0
- b. 1
- c. 2
- d. 3
- e. Greater than 3

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): _____