ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

Patient Confidential Health History

Patient Information
Page 1

MEDICAL HISTORY

Name _____ Today's Date_____

DOB ____/____/____ Age_____

Primary Physician _____ Referring Physician _____

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children (ages): _____

☐ Smoke_____ packs per day for _____ years ☐ Alcohol _____ use for_____ years

What is the reason for this visit? (Check all that apply)

☐ Varicose Veins ☐ Spider Veins ☐ Aching and Pain ☐ Itching and Burning ☐ Tiredness and Fatigue

☐ Restless Legs ☐ Swelling ☐ Leg Cramps ☐ Heaviness ☐ Skin Changes/Skin Ulcers

Other: _____

How long have you had these symptoms?: _____

VENOUS HISTORY

Do you have a FAMILY history of spider veins or varicose veins? ☐ Yes ☐ No

If so, please check and describe:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

Do you have a FAMILY history of deep venous thrombosis, stroke or clotting disorders? Describe which:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

SYMPTOMS

Please check if you have:

☐ Red spider veins ☐ Bulging veins ☐ Purple veins ☐ Flat bluish-green veins ☐ Abdominal veins

☐ Skin discoloration below your knee ☐ Leg ulcer ☐ Purple vein network ☐ Diagnosis of vein disease

Other: _____

Please describe. Do your legs or ankles:

Ache/hurt? _____ Swell? _____

Cramp? _____ Itch? _____

Become tired/Heavy? _____ Other? _____

Have you ever been treated for your veins before? ☐ Yes ☐ No

By whom? _____ When? _____

What method? _____

☐ Cosmetic Injections ☐ Laser for Spider Veins ☐ Ambulatory Phlebectomy ☐ Ultrasound-Guided Injections

☐ Radiofrequency closure ☐ Laser Catheter Ablation ☐ Stripping ☐ Ligation

Other: _____

What have your results been?_____

Are you being treated for any current medical conditions? ☐ Yes ☐ No If so, what are these conditions?

_____

Reviewed By_____

Date_____

ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

Patient Confidential Health History

Patient Information

Do YOU have a history of:

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

Past Surgical History. Please list any procedures you have had and the year.

_____ _____

_____ _____

_____ _____

_____ _____

Bleeding History. Please check all that apply.

- ☐ Excessive bleeding
- ☐ Easy Bruising
- ☐ Coumadin Use
- ☐ Aspirin Use
- ☐ Other _____

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

Medication	Dose	# Per Day/Frequency	Reason for Taking

Are you allergic to any medications?

Medication	Reaction

ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

Patient Confidential Health History
Patient Information

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

Ear, Nose, Mouth, and Throat:
- ☐ 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
- ☐ Migraine with aura
- ☐ Numbness/ tingling in extremities
- ☐ Incoordination
- ☐ Head trauma

Psych:
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Endocrine:
- ☐ Change of appetite
- ☐ Excessive thirst/urination
- ☐ Goiter

Hemato:
- ☐ Swollen lymph nodes
- ☐ Bleeding disorders

Immuno:
- ☐ Immune disorders
- ☐ Immunosuppressant

FEMALES ONLY

Breast:
- ☐ Lump
- ☐ Pain
- ☐ Nipple discharge
- ☐ Infection
- ☐ Trauma

Date of Last Mammogram_____

Date of Last pelvic exam_____

Gyn:
- ☐ Irregular periods
- ☐ Birth control
- ☐ Hormone therapy
- ☐ Menopause

Date of Last period _____

History of miscarriages; if so, how many_____

Signature _____ Date_____