TRIANGLE ORTHOPAEDIC PATIENT HISTORY/VEIN CLINIC

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____ AGE _____

MEDICAL DOCTOR _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

REVIEW OF SYSTEMS:
DO YOU AT PRESENT HAVE ANY OF THE FOLLOWING PROBLEMS? (PLEASE CIRCLE)

GENERAL:
FEVER/CHILLS YES NO
WEIGHT LOSS YES NO

HEENT:
SORE THROAT YES NO
HEARING LOSS YES NO

CARDIOVASCULAR:
ANGINA/CHEST PAIN YES NO
IRREGULAR HEARTBEAT YES NO
POOR CIRCULATION YES NO
SWELLING OF LEGS YES NO
EDEMA YES NO

PULMONARY:
COUGH YES NO
SHORTNESS OF BREATH YES NO

GASTROINTESTINAL:
BLACK TAR LIKE STOOLS YES NO
BLOODY STOOLS YES NO
DIARRHEA YES NO
NAUSEA/VOMITING YES NO

GENITOURINARY:
BLOOD IN URINE YES NO
BURNING W/URINATION YES NO
DIFFICULTY W/URINATION YES NO

NEUROLOGICAL:
ANXIETY/DEPRESSION YES NO
NUMBNESS/TINGLING YES NO
SEIZURES YES NO
MIGRAINES YES NO

HEMATOLOGICAL:
ANEMIA YES NO
BLEED EASILY YES NO
BRUISE EASILY YES NO

ENDOCRINE:
HEAT INTOLERANCE YES NO

SKIN:
RASH YES NO
VARICOSE VEINS YES NO

MUSCULOSKELETAL:
JOINT PAIN/MULTIPLE JOINT PAIN YES NO
JOINT SWELLING YES NO

FEMALES ONLY:
HAVE YOU HAD MENOPAUSE YES NO
CURRENTLY ON HORMONES YES NO

ANY ALLERGIC/UNUSUAL REACTIONS TO MEDICATIONS, FOODS, TAPE, LATEX, OR BETADINE? Y / N
IF YES, DESCRIBE REACTION _____

LIST ALL MEDICATIONS YOU TAKE (PRESCRIPTION, NONPRESCRIPTION, HERBAL AND VITAMINS)

MEDICINE	DOSE	#/DAY	MEDICINE	DOSE	#/DAY

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (PLEASE CIRCLE)

ALCOHOL DEPENDENCY
ANXIETY
ARTHRITIS TYPE _____
ASTHMA
BLOOD CLOTS
CANCER TYPE _____
CARDIAC DEFIB/PACEMAKER
CLAUSTROPHOBIA
COLITIS
CPAP MACHINE
DIABETES TYPE I ___ TYPE II ___
DEPRESSION
DRUG DEPENDENCY
EPILEPSY SEIZURES
EMPHYSEMA/COPD
FIBROMYALGIA
GASTRIC REFLUX/GERD
HEART PROBLEMS TYPE _____
HEPATITIS/LIVER FAILURE
HIV/AIDS
HIGH CHOLESTEROL
HYPERTENSION
KIDNEY DISEASE TYPE _____
LUNG PROBLEMS
LUPUS
MRSA
OSTEOPOROSIS
PSORIASIS
SLEEP APNEA
STOMACH ULCERS
STROKE/TIA
THYROID PROBLEMS

OTHER _____
LIST ALL SURGERIES/OPERATIONS _____
_____

HAS YOUR MOTHER OR FATHER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL PROBLEMS?

	MOTHER	FATHER		MOTHER	FATHER
ARTHRITIS	Y / N	Y / N	BLEEDING PROBLEMS	Y / N	Y / N
KIDNEY DISEASE	Y / N	Y / N	STROKE	Y / N	Y / N
HEART DISEASE	Y / N	Y / N	HIGH BLOOD PRESSURE	Y / N	Y / N
CANCER	Y / N	Y / N	BLOOD CLOTS	Y / N	Y / N
DIABETES			VARICOSE VEINS	Y / N	Y / N

OTHER_____

OCCUPATION _____ MARITAL STATUS S M D W SEPARATED

DO YOU USE? TOBACCO YES NO QUIT ALCOHOL YES NO QUIT
#YEARS _____ #/DAY _____ AMOUNT/DAY _____

HEIGHT: _____ WEIGHT: _____ B/P _____ TEMP _____

Are you seeking vein treatment for medical reasons, cosmetic reasons or both?	Medical	Cosmetic	Both
Do these symptoms interfere with your activities of daily living?	Yes	No	
How long have you had symptoms/veins that you are concerned about?_____			
Are they getting worse?	Yes	No	
Have you had any prior treatment for varicose/spider veins?	Yes	No	
If so, when and by whom?_____			
Do you have any history of poorly healing leg wounds or clots in your veins?	Yes	No	
Do you wear support hose?	Yes	No	
If so, prescription or over the counter?	Prescription	OTC	
How long have you been wearing them?_____			
Do they help?	Yes	No	
Do you take over the counter pain medication for your varicose/spider veins?	Yes	No	
Does it help?	Yes	No	
Do you elevate your legs to relieve your symptoms?	Yes	No	
Does it help?	Yes	No	

Symptoms	**Right Leg**	**Left Leg**
Spider Veins		
Varicose Veins		
Tired Legs		
Pain		
Leg Swelling		
Aching		
Burning/Itching		

Patient Signature _____ Date_____