

Venous Medical History Questionnaire

Rev. 5.10



84 MARGINAL WAY / SUITE 985

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www.SpectrumMedicalGroup.com

Patient Name _____ Date _____

Date of Birth _____ Age _____ Height _____ Weight _____

1. In a few words, please describe your medical problem: _____

How long have you had this problem? _____

2. What is the reason you are seeking medical treatment? Cosmetic Medical

3. Have you seen any other doctors for treatment of your veins (eg. surgery, injections, laser)? Yes No

If Yes, explain: _____

4. Are the problems that you are having in your legs interfering with your lifestyle? Yes No

If Yes, explain: _____

5. Do you experience any of the following symptoms in your legs? Restless Legs Heaviness Tiredness/Fatigue
 Itching/Burning Swollen Ankles Leg Cramps Throbbing Aching/Pain Problems Walking

6. Do you elevate your legs as much as possible? Yes No If Yes, does it help? Yes No

7. Do you wear, or have you ever worn, compression stockings for a minimum of 6 weeks?

If Yes, do/did they help? Yes No Please list what type you use(d) _____

8. Do you exercise regularly? Yes No If Yes, how often per week? _____

9. Are your symptoms worse at the end of the day? Yes No

10. Are you required to be on your feet for long periods of time? Yes No

11. Have you ever had blood clots, bleeding, or ulcers in your legs? Yes No

If Yes, please explain in detail when and in which leg: _____

12. Any other leg symptoms? Yes No

If Yes, please explain: _____

13. Are you pregnant, or planning a pregnancy soon? Yes No NA

14. Have you used any of the following medications for your symptoms? Advil Aspirin Aleve Anti-inflammatory

If Yes, did the medications help? Yes No Tylenol Motrin Naprosyn

15. Check off any of the following conditions you are currently experiencing or have experienced in the past: NONE

Head, Eyes, Ears, Nose, Throat

NONE

- Glaucoma
- Double Vision
- Dizzy Spells
- Severe Headache
- Ringing in Ears
- Nose Bleeds
- Difficulty Swallowing
- Cataracts
- Blindness
- Fainting Spells
- Seizures
- Deafness
- Sores in Mouth
- Hearing Loss
- Vision Loss

Cardiovascular / Respiratory

NONE

- Heart Failure
- Heart Attack
- Heart Murmur
- Chest Pain
- Persistent swelling in ankles
- High Blood Pressure
- Asthma
- Emphysema
- Chronic Cough
- Coughing up blood
- Shortness of breath on exertion

Gastrointestinal

NONE

- Weight Loss
- Weight gain
- Chronic Heartburn
- Liver Disease
- Yellow Jaundice
- Constipation
- Nausea
- Vomiting
- Ulcers
- Cirrhosis
- Irregular Bowels
- Bloody Stools
- Diarrhea
- Hepatitis
- Abdominal Pain

Endocrine

NONE

- Diabetes
- Excessive Thirst
- Lupus
- Thyroid
- Gout
- Rheumatism
- Arthritis
- Growth Problems
- Sensitive to hot or cold environment
- Unusual recent change in appearance
- Recent swelling in hands and feet
- Broken Bones

Genito-urinary

NONE

- Bloody Urine
- Venereal Disease
- Bladder Infections
- Kidney Disease
- Frequent Urination
- Painful Urination
- Loss of urine when sneezing/coughing

Neurologic

NONE

- Headache
- Weakness
- Stroke
- Tremors
- Seizures
- Loss of Coordination
- Tingling/Numbness
- Fainting Spells
- Speech Changes
- Functional Changes
- Confusion
- Nerve Disorder or "Nerve Troubles"

Coagulation

NONE

- Frequent Bruising
- Abnormal Clotting
- Abnormal Bleeding
- Bleeding after other operations

continued on other side

16. What is your personal history of prior hospital admissions and operations? (Include the year in which they occurred)

17. List allergies or bad reactions to drugs, sclerosants, foods, dyes, latex, rubber goods, etc.:

18. Have you had any problems with local anesthetics? Yes No

If Yes, please explain: _____

19. Have you taken any of these medications within the last year?

- steroids
- cortisone
- tranquilizers
- blood thinners
- frequent aspirin
- arthritis medicine
- high blood pressure medicine
- heart medicine
- nitroglycerine

Current Medications:	dose	Current Medications:	dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

20. Imaging studies: MRI CT Scan Other radiological study: _____

21. Labs: _____

22. What is the health status of your family?

Father: Living Deceased If deceased, cause of death: _____

Mother: Living Deceased If deceased, cause of death: _____

Siblings: Brothers _____ Sisters _____ Number Living _____

If deceased, cause of death: _____

Please check off any family history of the following conditions: Tuberculosis Cancer Gout Diabetes
 Bleeding Disorders Rheumatic Fever Heart Murmur Other: (specify) _____

23. What is your social history?

Marital Status: Married Single Divorced Widow/Widower

Present Occupation _____

Number of living children _____ Number of people in household _____

Do you use tobacco? Yes No If Yes, amount per day _____

Do you drink alcoholic beverages (beer, liquor, etc.)? Yes No If Yes, number of drinks per day: _____

➡ Patient Signature _____ Date _____

Reviewed by Physician with Patient _____
Physician signature Date reviewed

I have reviewed and amended as appropriate _____
Physician signature Date reviewed

I have reviewed and amended as appropriate _____
Physician signature Date reviewed