Vein Healthcare Center

100 Foden Road | Suite 307, Building West | S. Portland, Maine 04106
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Medical Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Primary care provider: _____

Vein History

Do your legs bother you? ☐Yes ☐No If yes, please check all that apply:

- ☐ Aching
- ☐ Cramping
- ☐ Throbbing
- ☐ Pain
- ☐ Swelling
- ☐ Itching
- ☐ Heaviness
- ☐ Ulcers
- ☐ Numbness

Other/Comments: _____

_____

Have you ever worn compression stockings? ☐Yes ☐No If yes, when and for how long? _____

Have you had past vein treatment or had leg veins examined by a physician? ☐Yes ☐No If yes, please describe: _____

_____

Do you ever take Aspirin, Tylenol, or Ibuprofen for your leg symptoms? ☐Yes ☐No

Do your legs prevent you from doing any activities (e.g. standing for long periods, swimming, wearing shorts, sleeping)? ☐Yes ☐No If yes, please describe: _____

_____

Have you had injury to your legs requiring casting? ☐Yes ☐No

Please check any of the medical conditions below that you have experienced:

- ☐ Deep Vein Thrombosis (DVT)
- ☐ Superficial Vein Phlebitis
- ☐ Venous Stasis Ulcer
- ☐ Bleeding from Varicose Veins
- ☐ Vein Treatment
- ☐ Other _____

Medical History

Do you see a doctor regularly for any medical condition? ☐Yes ☐No If yes, please describe: _____

_____

_____

Please check any health or disease related issues you might have:

- ☐ AIDS
- ☐ Anemia
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Stroke
- ☐ Ulcers
- ☐ Other? _____

Medical Information

Have you had any serious injuries? ☐Yes ☐No If yes, please list the date and type of injury: _____

_____

_____

Past Surgeries

Please list past surgeries:

_____ _____ _____

_____ _____ _____

Family History

	Major Illness	Age	Deceased?
Mother:	_____	_____	☐Yes ☐No
Father:	_____	_____	☐Yes ☐No
Sibling 1:	_____	_____	☐Yes ☐No
Sibling 2:	_____	_____	☐Yes ☐No
Sibling 3:	_____	_____	☐Yes ☐No

Social History

Current/Past occupation?: _____ Marital status: _____

Do you smoke? ☐Yes ☐No How much? Quit date? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much? _____

Do you exercise? ☐Yes ☐No If yes, please describe: _____

Medication

Please list current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

OB History (Women only)

Is there a chance that you are pregnant? ☐Yes ☐No How many times have you been pregnant? _____

How many children have you birthed? _____ Complications? _____

_____

Allergies

Please list allergies:

_____ _____ _____

_____ _____ _____

Medical Conditions *(circle any that apply)*

General Health: Recurrent infections/fever, fatigue, recent weight gain or loss, night sweats, decreased appetite. Comments: _____

_____

Emotional: Depression, anxiety attacks, crying spells, alcohol/drug problems, problems falling asleep, nervousness, suicidal thoughts. Comments: _____

_____

Eyes: Wear glasses or contacts, eye infections, blurred vision. Comments: _____

_____

Medical Information

Medical Conditions *continued*

Head, Ears, Nose, Mouth, Throat: Ear infections, headaches, fullness in head, sore throat, nose bleeding. Comments: _____

Heart: Chest discomfort, tightness, heart murmur, swollen ankles, shortness of breath, rheumatic fever, high blood pressure. Comments: _____

Lungs: Difficulty breathing, cough, wheezing, cough blood or mucus, sleep on more than one pillow. Comments: _____

Lymphatic/Blood Vessels: Excessive bleeding, bruise easily, swollen lymph nodes. Comments: _____

Muscle/Bone/Joints: Joint pain, stiffness, swelling, muscle pain, muscle cramping or spasms, neck/back pain. Comments: _____

Nervous System: Fainting or loss of consciousness, convulsions, seizures, dizziness, memory changes. Comments: _____

Reproductive: Burning pain when urinating, frequent urination, sudden impulse to urinate, irregular periods, clots, cramps, prostate problems. Comments: _____

Skin/Breasts: Sore, rash/itching, lumps/growths, changes in moles, hair loss, swollen glands, tenderness or pain in breasts, discharge from breasts. Comments: _____

Stomach and Intestinal: Special diet, change in appetite, heartburn, nausea/vomiting, problems swallowing, black stools, ulcers, constipation, use antacids. Comments: _____

Other: Please describe any other medical conditions you may have: _____

Additional Medical Information

Please share any details about your health that you feel may be relevant and not previously mentioned?:

_____

_____

_____

_____

_____

_____

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