



Wisconsin Vein Center & MediSpa

## Confidential Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours standing per day: \_\_\_\_\_

Which leg bothers you?  Right  Left  Both

### SYMPTOMS please check if you have:

- Ache or hurt
- Swell
- Cramp
- Become restless
- Become tired/heavy
- Itch/burn
- Ulceration/skin changes on leg
- Bleeding from a bulging vein
- Leg discomfort with menses
- No symptoms

### For Women:

- Pelvic heaviness
- Symptoms worsen with menses

What **treatments** have you tried to relieve these symptoms?

- Analgesic Usage  Compression Hose  Elevation  Walking

Number of year's symptoms has been present \_\_\_\_\_

Have you ever had any previous vein treatments?  Yes  No

If yes, what treatments have you had?

- Vein stripping
- Laser ablation
- Radiofrequency ablation
- Sclerotherapy
- Other

Have you ever worn compression hose?  Yes  No

If yes, # of years worn: \_\_\_\_\_

Please list any **surgeries** you have had \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

OVER →

Do you have any **allergies**?  Yes  No

If Yes, please list: \_\_\_\_\_

**Reaction:** \_\_\_\_\_

Please list any **medications** you take \_\_\_\_\_

Do you smoke?  Yes  No If Yes, how many per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No

If yes, please check what type  Beer  Wine  Other \_\_\_\_\_

How often do you drink? \_\_\_\_\_

Do you use any illicit drugs? (Cocaine, Marijuana)  Yes  No

How often do you exercise?  Daily  Weekly  Frequently  Not Regularly

**Are you currently being treated for or have any history of:**

- |   |   |
|---|---|
| <input type="checkbox"/> Anemia                                 | <input type="checkbox"/> Kidney disease                                     |
| <input type="checkbox"/> Ankle Skin changes                     | <input type="checkbox"/> Leg ulcers or non-healing wounds                   |
| <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Liver disease                                      |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Lupus  |
| <input type="checkbox"/> Chest pain discomfort                  | <input type="checkbox"/> Migraine headaches                                 |
| <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> Mitral valve prolapse                              |
| <input type="checkbox"/> Clotting / bleeding disorders          | <input type="checkbox"/> Peripheral vascular disease                        |
| <input type="checkbox"/> Congestive heart failure               | <input type="checkbox"/> Pulmonary embolus                                  |
| <input type="checkbox"/> Crohn's disease, IBS                   | <input type="checkbox"/> Rupture of vein                                    |
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Deep vein thrombosis/blood clot in leg | <input type="checkbox"/> Stroke / TIA                                       |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Structural heart defect                            |
| <input type="checkbox"/> Easy bruisability                      | <input type="checkbox"/> Superficial Thrombophlebitis<br>(red or hard vein) |
| <input type="checkbox"/> Heart disease                          | <input type="checkbox"/> Trauma to legs / leg fracture                      |
| <input type="checkbox"/> Hepatitis                              | <input type="checkbox"/> <b>Men:</b> Testicular Varicosities                |
| <input type="checkbox"/> HIV                                    | <input type="checkbox"/> <b>Women:</b> Vulvar (Labial ) varicosities        |
| <input type="checkbox"/> Hypertension                           | <input type="checkbox"/> <b>Other</b> _____                                 |
| <input type="checkbox"/> Other _____                            | <input type="checkbox"/> <b>Other</b> _____                                 |

Is there a family history of varicose vein disease?  Yes  No

Are you pregnant?  Yes  No

# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_

