

Austin Vein and Vascular Clinic

Female Patient Health History Form

Name: _____ Age: _____ Date: _____

How did you hear about us? _____

Did a physician refer you? If so, whom? _____

Please briefly describe your chief complaint: _____

Past Medical History

1. Have you ever had vein surgery, vein injections, laser treatment, or any other type of vein treatment?

Yes

No

If yes, what type and when? _____

2. Have you had any tests done or evaluations of your veins? Yes

No

If yes, who, what, and when? _____

2. Have you ever had a blood clot?

Yes

No

If yes, what leg and when? _____

Were you treated with a blood thinner (Heparin, Coumadin)?

Yes

No

3. Have you ever had phlebitis (inflammation of a vein)? Yes

No

If yes, what leg and when? _____

Child Rearing History

1. Are you presently pregnant?

Yes

No

2. How many times have you been pregnant? _____

3. Do you intend to have any more children?

Yes

No

Family Medical History

1. Does anyone in your family have varicose veins, spider veins, or leg ulcers?

Yes

No

Current History

- | | | |
|-------------------------------|-----|----|
| 1. Do you have heart disease? | Yes | No |
| Lung disease | Yes | No |
| High blood pressure | Yes | No |
| Arthritis | Yes | No |
| Other _____ | | |

2. Do you have any allergies (medicines, latex, tape, food)? Yes _____ No

3. Please list any medications you take including prescription and over-the-counter.

- | | | |
|-----------------------------------------------------------|-----|----|
| 4. Do you experience any of the following with your legs? | | |
| Aching/pain | Yes | No |
| Heaviness | Yes | No |
| Tiredness/fatigue | Yes | No |
| Itching/burning | Yes | No |
| Swollen ankles | Yes | No |
| Cramping/throbbing | Yes | No |

- | | | |
|--------------------------------|-----|----|
| 5. Do you have varicose veins? | Yes | No |
| Spider veins? | Yes | No |
| For how long? _____ | | |

- | | | |
|---------------------------------------------------|-----|----|
| 6. Have your veins gotten worse in recent months? | Yes | No |
|---------------------------------------------------|-----|----|

7. How long have you had leg discomfort? _____

8. What methods do you use to relieve your leg discomfort?

- Compression stockings/support hose
If yes, how long have you worn them? _____
Do they help? _____

- | | |
|-----------------|--------------|
| ○ No discomfort | ○ Aspirin |
| ○ Leg Elevation | ○ Tylenol |
| ○ Exercise | ○ Ibuprofen |
| ○ Walking | ○ Pain meds |
| ○ Warm Soaks | ○ Other |
| ○ Cold Packs | method _____ |