

## Female Patient Health History Form

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

Please briefly describe your chief complaint: \_\_\_\_\_  
\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

### **PAST MEDICAL HISTORY**

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

Yes No If yes, what type and when? \_\_\_\_\_

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

Yes No If yes, who, what, and when? \_\_\_\_\_

Have you ever had a blood clot?

Yes No If yes, what leg and when? \_\_\_\_\_

- If yes, were you treated with a blood thinner (Heparin, Coumadin)? Yes No

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

Yes No If yes, what leg and when? \_\_\_\_\_

### **CHILD REARING HISTORY**

Are you presently pregnant? Yes No How many times have you been pregnant? \_\_\_\_\_

If of childbearing age, do you intend to have any more children? Yes No

### **FAMILY HISTORY**

Does anyone in your family have varicose veins, spider veins, or leg ulcers? Yes No

Who? \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

**CURRENT HISTORY**

**Do you currently have any of the following:**

Heart Disease	Yes	No	High blood pressure	Yes	No
Lung Disease	Yes	No	Arthritis	Yes	No
Allergies ( <i>medicines, latex, tape, shellfish, etc.</i> )			Yes	No	

→ If yes, please specify: \_\_\_\_\_

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

**Do you experience any of the following with your legs:**

Aching/pain	Yes	No	Tiredness/fatigue	Yes	No
Heaviness	Yes	No	Itching/burning	Yes	No
Swollen ankles	Yes	No	Cramping/throbbing	Yes	No

**Do you have any of the following (circle):**    Varicose veins    Spider veins    For how long? \_\_\_\_\_

**Have your veins gotten worse in recent months?**    Yes                  No

**Do you have discomfort in your legs?**    Yes    No    How long have you had leg discomfort? \_\_\_\_\_

**If you have leg discomfort, what methods do you use to relieve it (circle):**

Compression stockings/support hose:    *Do they provide relief?*    Yes    No

→ If yes, how long have you worn them? \_\_\_\_\_

Leg Elevation	Walking	Cold Packs	Tylenol	Pain meds
Warm Soaks	Ibuprofen	Aspirin	Exercise	