

# VEIN centers for excellence™

*No one knows legs like we do!™* of Lake County

## Medical History

The following information will help your physician plan your care. PLEASE PRINT AND COMPLETE EACH SECTION.

Appointment Date: \_\_\_\_\_ Name: \_\_\_\_\_  
 Male \_\_\_ Female \_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

For what problem are you seeking care? \_\_\_\_\_  
 \_\_\_\_\_

How long has it been present? \_\_\_\_\_

If you have had any previous treatment for this problem, when? \_\_\_\_\_  
 Describe the treatment \_\_\_\_\_

If pain is present, please describe: How often \_\_\_\_\_ Severity (1-10, 10 severe) \_\_\_\_\_  
 What makes pain worse? \_\_\_\_\_  
 What makes pain better? \_\_\_\_\_

Check and/or list all illnesses you have been treated for in the past and the present:

- none       heart attack       angina       heart murmur       mitral valve prolapse
- high blood pressure       stroke       asthma/emphysema       blood clots
- low blood pressure       stomach trouble/ulcer       bleeding disorder       hepatitis
- COPD       kidney problems       seizures       bladder       arthritis       diabetes       TB
- cancer       depression       cirrhosis       **migraines/headaches**       **HIV/AIDS**
- other \_\_\_\_\_

Surgical history:       heart surgery       hysterectomy       **vein surgery**  
                                   pacemaker       peripheral vascular disease       other \_\_\_\_\_

List all medications you are now taking.

- \_\_\_\_\_ None
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_

Drug allergies \_\_\_\_\_ Latex? \_\_\_\_\_ Iodine? \_\_\_\_\_  
 Type of work? \_\_\_\_\_  
 Tobacco use? \_\_\_\_\_  
 Alcohol use? \_\_\_\_\_