



598 Nancy St,  
Suite 150  
Marietta, GA 30060

### PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age \_\_\_\_\_  Male  
 Female Occupation \_\_\_\_\_

Were you referred by your physician:  yes  no  
If yes, name: \_\_\_\_\_

**Symptoms:** (check all that apply)

- |   |         |  |         |
|---|---------|--|---------|
| <input type="checkbox"/> Pain/aching in leg | RT / LT | <input type="checkbox"/> Itching/burning   | RT / LT |
| <input type="checkbox"/> Leg cramps         | RT / LT | <input type="checkbox"/> Ulcers/ulceration | RT / LT |
| <input type="checkbox"/> Skin changes       | RT / LT | <input type="checkbox"/> Leg Restlessness  | RT / LT |
| <input type="checkbox"/> Throbbing          | RT / LT | <input type="checkbox"/> Tiredness/fatigue | RT / LT |
| <input type="checkbox"/> Swelling           | RT / LT |  |         |

Do you take any medications to relieve above symptoms?:  yes  no

Additional Comments: \_\_\_\_\_

Are your symptoms worse with: \_\_\_\_\_ Are your symptoms relieved with: \_\_\_\_\_  
 Prolonged standing/sitting  menstrual cycle?  rest  elevation of leg?

How many years have you had this/these Symptoms? \_\_\_\_\_ What made you decide to seek treatment at this time? \_\_\_\_\_

Have you worn support or compression hose?  Yes  No  
If yes, how long?  1-3 months  3-6 months  6 months+

**Female:**  my symptoms worse before or during menstrual cycle  
 I am pregnant or actively trying to become pregnant  
 I am on hormone therapy i.e., estrogen, premarin, provera, birth control, etc.  
Number of pregnancies: \_\_\_\_\_ Number of Deliveries: \_\_\_\_\_

List any Allergies you have:  
\_\_\_\_\_  
\_\_\_\_\_

List all medications you are taking including non prescription:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family history** of varicose veins/spider veins (please check all that apply)  
mother father sister brother grandmother grandfather  aunt uncle

**PREVIOUS VEIN TREATMENT HISTORY:**

Vein Surgery  Injections  laser  vein evaluations  other  
If any  checked, where/when: \_\_\_\_\_

**MEDICAL HISTORY:**

- |   |  |  |  |                                     |
|---|--|--|--|-------------------------------------|
| <input type="checkbox"/> blood clots- leg   | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart disease | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> hepatitis  |
| <input type="checkbox"/> blood clots - lung | <input type="checkbox"/> leg ulcer           | <input type="checkbox"/> diabetes      | <input type="checkbox"/> seizures          | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> leg injury         | <input type="checkbox"/> leg swelling        | <input type="checkbox"/> asthma        | <input type="checkbox"/> cancer            | <input type="checkbox"/> stroke     |
- hospitalizations; explain: \_\_\_\_\_  
 other: \_\_\_\_\_