Isam A. Haddadin M.D., F.A.C.S.
Medical Director
3641 Ridge Road, Highland, IN 46322
219/923-2400 Fax 219/923-2424

VEIN PATIENT HEALTH HISTORY FORM

Name ______________________________ Date ______________

Sex ❑ M ❑ F Age ______ What type of work do you do? ______________

PATIENT HISTORY

Please answer the following questions, trying not to leave any blank spaces.

1. For what reason are you seeking treatment for your veins? ❑ Medical ❑ Cosmetic
2. What is the main complaint for which you are seeking care? ______________
3. How long has this been a problem? ______________
4. Aggravated by? ______________

Do you experience any of the following symptoms in your legs? Please check yes or no.

- Aching or Pain ❑ Yes ❑ No
- Heaviness ❑ Yes ❑ No
- Tiredness or Fatigue ❑ Yes ❑ No
- Itching or Burning ❑ Yes ❑ No
- Swollen Ankles ❑ Yes ❑ No
- Leg Cramps ❑ Yes ❑ No
- Restless Legs ❑ Yes ❑ No
- Throbbing ❑ Yes ❑ No
- Leg Ulcers: Clots, Dark Pigmentation, Bleeding ❑ Yes ❑ No
- Other ❑ Yes ❑ No
  - Explain ______________
- Have your veins gotten worse in recent months? ❑ Yes ❑ No
- Do you elevate your legs to relieve discomfort? ❑ Yes ❑ No
- Do you wear support hose prescribed by a doctor? ❑ Yes ❑ No
  - If yes, what type? ______________
- Do you wear light support hose (sheer)? ❑ Yes ❑ No
- Do they provide relief? ❑ Yes ❑ No
- Do you have any problems walking? ❑ Yes ❑ No
  - If yes, how does it affect you? ______________
- Do you stand much at work? ❑ Yes ❑ No
- Do you stand much at home? ❑ Yes ❑ No
- Have you ever had your veins evaluated before? ❑ Yes ❑ No
  - If yes, when & where? ______________
- Have you had any tests done on your veins before? ❑ Yes ❑ No

Patient's Initials ______

MEDICAL HISTORY

Have you ever been in the hospital as a patient? ❑ Yes ❑ No

If yes, for what reason? ______

Have you ever had surgery? ❑ Yes ❑ No

If yes, please circle and explain.

Heart Bypass	Valve	Pace Maker	Defibrillator
Artificial Joints	Prosthetics	Spinal Surgery	Discs
Arterial Bypass	Carotid Artery	Aneurysm	Gall Bladder
Appendix	Colon	Stomach	Hernia
Hysterectomy	Tubal Ligation	Ovaries	Other

Explain ______

Have you ever had vein stripping surgery? ❑ Yes ❑ No

If yes, when, where and which leg? ______

Have you ever had vein injections? ❑ Yes ❑ No

If yes, when, where and which leg? ______

Did you ever have a **major injury to your leg or thigh**? ❑ Yes ❑ No

If yes, which leg, what injury and when? ______

Are you presently under the care of a physician? ❑ Yes ❑ No

If yes, for what illness? ______

Do you have any of the following?

- Heart Disease ❑ Yes ❑ No
- Lung Disease (Asthma/Emphysema) ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No
- Hepatitis or Liver Cirrhosis ❑ Yes ❑ No
- Arthritis ❑ Yes ❑ No
- Kidney Problems ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No
- Stroke ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Leg Ulcers ❑ Yes ❑ No
- Diabetes Mellitus ❑ Yes ❑ No
- Blood Clotting Disease ❑ Yes ❑ No

Have you ever had a blood clot? ❑ Yes ❑ No

If yes, which leg and when? ______

Have you ever had phlebitis? ❑ Yes ❑ No

If yes, which leg and when? ______

CHILD BEARING HISTORY

Do you think you are presently pregnant? ❑ Yes ❑ No

How many children do you have? ______

Do you intend to have any more children? ❑ Yes ❑ No

Are you presently breast feeding? ❑ Yes ❑ No

Does your vein problem get worse around menstruation time? ❑ Yes ❑ No

Patient's Initials ______

FAMILY HISTORY

Does any member of your family suffer from
varicose veins, spider veins, leg ulcers or swollen legs? . . . . . ❑ Yes ❑ No
If yes, who and what ailment? ________________

Do you know of any other diseases in your family history? . . . . . ❑ Yes ❑ No
If yes, who and what disease? ________________

Do you know of any
common causes of death in your family history? . . . . ❑ Yes ❑ No
If yes, please circle and explain.
Cancer Heart Disease Stroke Blood Clots
Other ________________

MEDICAL ALLERGIES

Are you presently taking any medication, including prescriptions and/or non-prescription
(over-the-counter) medicines, pain relievers, vitamins, etc.? . . ❑ Yes ❑ No
If yes, please list them. ________________

____

____

Do you take any blood thinning medications
(Coumadin, Plavix, etc.)? . . . . ❑ Yes ❑ No
If yes, please list them ________________

Do you take aspirin (Ascripting, Ecotrin, etc.)? . . . . ❑ Yes ❑ No

Do you take hormones or birth control pills? . . . . ❑ Yes ❑ No

Do you have any allergies to medicine, pollen, etc.? . . . . ❑ Yes ❑ No
If yes, please list allergy and reaction ________________

____

____

Are you allergic to any foods
(shrimp, shellfish, iodine, IVP dye)? . . . . ❑ Yes ❑ No

Are you allergic to latex
(rubber gloves, balloons, elastic bandages, etc.)? . . . . ❑ Yes ❑ No

HABITS

Do you drink coffee? . . . . ❑ Yes ❑ No
If yes, how many cups per day? ________________

Do you smoke or chew tobacco? . . . . ❑ Yes ❑ No
If yes, how many packs per day? ________ For how many years? ________
Do you intend to quit? . . . . ❑ Yes ❑ No

Do you drink alcohol? . . . . ❑ Yes ❑ No
If yes, how often (daily, weekly, occasionally)? ________________

Patient's Signature ________________ Date ________

Physician's Signature ________________ Date ________