Isam A. Haddadin M.D., F.A.C.S
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VEIN CARE CENTER PATIENT HISTORY FORM

Name: ____ Date: ___________________

Sex: M / F Date of Birth: __________________ 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? __________________ Aggravated by? __________________________

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

Aching or Pain	Yes / No	Leg Cramps	Yes / No
Heaviness	Yes / No	Restless Legs	Yes / No
Tiredness or Fatigue	Yes / No	Throbbing	Yes / No
Itching or Burning	Yes / No	Swollen Ankles or legs	Yes / No
Leg Ulcers	Yes / No		

Clots, Dark Pigmentation, Bleeding Yes / No

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/stocking prescribed by a doctor?	Yes / No
Do they provide relief?	Yes / No
Do you stand much at work?	Yes / No
Did you do heavy weight lifting (sport or job)	Yes / No
Have you ever had your veins evaluated before?	Yes / No

MEDICAL HISTORY

Have you ever been in the hospital as a patient? Yes / No if yes, for what? ___________

Have you ever had surgery? (please circle if yes)

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

Other please explain:____

Have you ever had vein stripping surgery?	Yes / No	if yes, when? ____________
Have you ever had vein injections?	Yes / No	if yes, when? ____________
Did you ever have a **major injury to your leg or thigh?**	Yes / No	if yes, when? ____________
Are you presently under the care of a physician?	Yes / No	

Who is your family physician? ____

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Do you have any of the following?

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

Have you ever had a blood clot? Yes / No if so, which leg & when? ____________________
ANY CLOTTING PROBLEMS? Yes / No
(diagnosed or suspected)

CHILD BEARING HISTORY
How many children do you have? ___________ Are you presently breast feeding or pregnant? _____________
DOES YOUR VEIN PROBLEM SYMPTOMS GET WORSE AROUND MENSTRUATION TIME? _______

FAMILY HISTORY
Does any member of your family suffer from:
varicose veins, spider veins, leg ulcers, or swollen legs? Yes / No if yes, who? _____________
Do you know of any other diseases in your family history? Yes / No if yes, who? _____________
Do you know of any **blood clotting disease in your family? Yes / No**
if so, please explain: ____

MEDICATIONS
Are you presently taking any medication, including prescriptions and/or non prescription (over-the-counter) medications, pain relievers, vitamins, etc? Yes / No
Please list them____
____
Do you take any blood thinning medications? Coumadin, Plavix, Aspirin & Other. Please list
____
____
Do you take hormones or birth control pills? Yes / No

MEDICAL ALLERGIES
Do you have any allergies to any medications or food? Yes / No
if yes, please list allergy and the reaction ____
Are you allergic to **latex**? Yes / No if so, what happens? ______________________________________

HABITS
Do you smoke or chew tobacco? Yes / No if so, how many cigarettes daily? ____________________
Do you drink alcohol? Yes / No if so, how often (daily, weekly, occasionally) ___________

Patient's Signature ____ Date: __________________________

Physician's Signature ______________________________________ Date: __________________________