



Connecticut Vein Care

MEDICAL HISTORY FORM

DATE: _____

NAME: _____

AGE: _____ OCCUPATION: _____

How did you hear about Connecticut Vein Care? _____

REASON FOR DOCTOR VISIT: (Include onset and duration of symptoms.)

Check any that apply:

Aching sensation

Heaviness

Pain on standing

Swelling

Redness

Tender to touch

Skin discoloration

Varicose Veins

Ulcer of the skin

OPERATIONS: If none please circle - NONE

PLEASE TURN OVER TO COMPLETE

MEDICATIONS : (INCLUDE DOSAGE AND HOW OFTEN YOU TAKE IT.)

If none please circle - NONE

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

ALLERGIES TO MEDICATIONS (INCLUDE THE REACTION YOU HAD):

If none please circle - NONE

SMOKING HISTORY ___YES ___NO. OR: ___ YEARS SINCE YOU QUIT.

DO **YOU** HAVE A HISTORY OF:
(CHECK ALL THAT APPLY) or Circle – NONE

DO YOU HAVE A **FAMILY** HISTORY OF:
(CHECK ALL THAT APPLY) or Circle - NONE

- HYPERTENSION _____
- DIABETES _____
- BLOOD CLOTS (PHLEBITIS) _____
- HEART ATTACK _____
- PALPITATIONS _____
- PNEUMONIA _____
- EMPHYSEMA _____
- ASTHMA _____
- STROKE _____
- KIDNEY DISEASE _____
- LIVER DISEASE _____
- BLEEDING TENDENCY _____
- CANCER _____
- THYROID DISEASE _____
- MENTAL ILLNESS _____
- OTHER _____

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- THYROID DISEASE _____
- MENTAL ILLNESS _____
- OTHER _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

REVIEWED BY: _____
DATE: _____

- Subsequent Review
- Date Reviewed: ___/___/___ Provider signature: _____
 - Date Reviewed: ___/___/___ Provider signature: _____
 - Date Reviewed: ___/___/___ Provider signature: _____
 - Date Reviewed: ___/___/___ Provider signature: _____