FORM 154 Patient History

TotalVeinCare
Comprehensive Treatment of Vein Disorders

TotalVeinCare.net 859.278-4960

Patient Name _____ DOB ____/____/____ Date_____

Preferred Pharmacy _____ City _____ Phone _____

REASON FOR VISIT _____

Referring Physician:_____ Primary Care Physician _____

PERSONAL HEALTH HISTORY: (*Please check all that apply.*) **Anesthesia Complications:** ____ Yes ____ No

- ❑ Abdominal Obesity
- ❑ Abdominal Aortic Aneurysm
- ❑ Asthma
- ❑ Cancer *(specify)* _____
- ❑ GERD
- ❑ Hernia
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Coronary Artery Disease
- ❑ Diabetes
- ❑ Gallbladder Disease
- ❑ Gallstones
- ❑ Peripheral Vascular Disease
- ❑ Stroke
- ❑ Hiatal Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Congestive Heart Failure (CHF)
- ❑ Other (specify):

SURGICAL HISTORY: *(List below)* or if none, please write "No surgeries" in slot 1.

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

Other (specify):

FAMILY HISTORY:

	Blood Relative		Blood Relative		Blood Relative
Aneurysm		Diabetes		High Cholesterol	
Bleeding disorder/Blood Clots		Heart Disease		Stroke	
Cancer (specify):		High Blood Pressure		Varicose Veins	

Other (specify):

ALLERGIES/DRUG ALLERGIES: ❑ No Known Drug Allergies ❑ Drugs (specify): _____
❑ Latex ❑ Shellfish ❑ Other (specify): _____

MEDICATIONS (with dose):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Additional Prescription Medications:_____

SOCIAL HISTORY:

Tobacco Use: ❑ Never Smoker ❑ Former Smoker ❑ Current Smoker # ____ packs per day

Alcohol Use: ❑ None ❑ Occasional Use ❑ Moderate Use ❑ Heavy Use

Occupation: _____ or ❑ Retired ❑ Disabled ❑ None

Patient Name: _____ DOB: _____/_____/_____ Date_____

REVIEW OF SYSTEMS: Please circle YES or NO to all of the following symptoms:

GENERAL			Limb Swelling	YES	NO
Chills	YES	NO	Phlebitis	YES	NO
Dietary Changes	YES	NO	Slow Pulse	YES	NO
Fatigue	YES	NO	**GASTROINTESTINAL**		
Persistent Infections	YES	NO	Abdominal Pain	YES	NO
Weight Gain	YES	NO	Black, Tarry Stool	YES	NO
Weight Loss	YES	NO	Constipation	YES	NO
SKIN			Difficulty Swallowing	YES	NO
Bruising	YES	NO	Heartburn	YES	NO
Inflammation of Skin	YES	NO	Jaundice	YES	NO
Rash	YES	NO	Nausea/Vomiting	YES	NO
Ulcer	YES	NO	Rectal Bleeding	YES	NO
HEENT			**GENITOURINARY**		
Blurred Vision	YES	NO	Blood in Urine	YES	NO
Dizziness	YES	NO	Difficulty Urinating	YES	NO
Double Vision	YES	NO	Incontinence	YES	NO
Headache	YES	NO	Impotence – male only	YES	NO
Visual Loss	YES	NO	**MUSCULOSKELETAL**		
NECK			Limb Pain with Walking	YES	NO
Neck Mass	ES	NO	**NEUROLOGICAL**		
Neck Pain	YES	NO	Fainting	YES	NO
Swollen Glands	YES	NO	Seizures	YES	NO
RESPIRATORY			Stroke	YES	NO
Chronic Cough	YES	NO	**PSYCHIATRIC**		
Shortness of Breath	YES	NO	Anxiety	YES	NO
BREAST			Depression	YES	NO
Breast Mass	YES	NO	Suicidal Ideation	YES	NO
Breast Pain	YES	NO	**ENDOCRINE**		
Breast Swelling	YES	NO	Thyroid Problems	YES	NO
Nipple Discharge	YES	NO	**HEMATOLOGY**		
Nipple Pain	YES	NO	Anemia	YES	NO
CARDIOVASCULAR			Blood Clots	YES	NO
Abnormal Blood Pressure	YES	NO	Prolonged Bleeding	YES	NO
Heart Stent	YES	NO	Irregular Heart Beat	YES	NO