PATIENT MEDICAL HISTORY

MUST COMPLETE ENTIRE FORM

PLEASE PRINT

Name____Age_________

MEDICAL HISTORY (PLEASE CHECK YES OR NO)

YES	NO		YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	PULMONARY EMBOLUS	☐	☐	HEPATITIS
☐	☐	HEART DISEASE	☐	☐	BLEEDING DISORDER	☐	☐	SEIZURES
☐	☐	PHLEBITIS	☐	☐	BLOOD CLOTS	☐	☐	DIABETES
☐	☐	MIGRAINE HEADACHES	☐	☐	MITRO VALVE PROLAPSE	☐	☐	LYMPHADEMA

SURGICAL HISTORY (LIST ALL SURGERIES)____

LIST MEDICATIONS YOU ARE TAKING ______________________________

ALLERGIES-SENSITIVITIES (DRUGS AND FOOD)_______________________________

DO YOU HAVE (PLEASE CHECK)

☐ LEG PAIN ☐ TIRED/HEAVY LEGS ☐ SKIN CHANGES
☐ TENDERNESS ☐ LEG CRAMPS ☐ RED/WARMNESS
☐ ACHING/THROBBING ☐ ITCHING ☐ ULCERS
☐ BURNING/STINGING ☐ SWELLING ☐ OTHER

HOW MANY YEARS HAVE YOU HAD THIS PROBLEM
____

ARE YOUR SYMPTOMS WORSE WITH
☐ PROLONGED STANDING/SITTING

ALCOHOL INTAKE: _____NEVER _____RARE _____OCCASIONAL/SOCIAL _____DAILY

SMOKING: ____NEVER ____FORMER SMOKER ____ EVERYDAY ____SOMEDAYS

CAFFEINE: _____NONE_____SOME_____ AVERAGE _____EXCESSIVE

PREGNANCIES_____ DELIVERIES______

HEIGHT_____________ WEIGHT____________

FAMILY HISTORY OF VARICOSE/SPIDER VEINS(PLEASE CIRCLE)

MOTHER/FATHER/SISTER/BROTHER/GRANDMOTHER/GRANDFATHER/UNCLE/AUNT

PREVIOUS VEIN TREATMENT (AND WHERE WAS TREATMENT DONE)

____

Have you ever worn gradient compression hose_______ How long did you wear them____