BELLAMAH VEIN CENTER

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Confidential - *Fill out in Black or Blue Pen*

Patient Name _____ Today's Date _____

Age _____ Birthdate _____

What is your reason for your visit today? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness. numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Itching
- ☐ Scars
- ☐ Sore that won't heal

Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y	☐ N
Phlebitis (vein redness/tenderness)	☐ Y	☐ N
Blood clots	☐ Y	☐ N
Deep vein thrombosis (DVT) and/or Pulmonary embolism (PE)	☐ Y	☐ N
Saphenous vein reflux	☐ Y	☐ N

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y	☐ N	Cramps	☐ Y	☐ N
Heaviness/fatigue	☐ Y	☐ N	Restless legs	☐ Y	☐ N
Itching/burning	☐ Y	☐ N	Throbbing	☐ Y	☐ N
Swelling	☐ Y	☐ N	Skin or ulcer problems	☐ Y	☐ N
Skin discoloration	☐ Y	☐ N	Bleeding from veins	☐ Y	☐ N

Family and Treatment History

Have any of your family members had:

Varicose vein problems	☐ Y ☐ N	Who?	_____
Vein stripping	☐ Y ☐ N	Who?	_____
Clotting disorder	☐ Y ☐ N	Who?	_____
Blood clots	☐ Y ☐ N	Who?	_____
Stroke, heart attacks or pulmonary emboli	☐ Y ☐ N	Who?	_____

Your Vein Treatment History

Sclerotherapy	☐ Y	☐ N
Phlebectomy	☐ Y	☐ N
Vein stripping surgery and/or Laser therapy	☐ Y	☐ N

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Health History

Symptoms

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	HEALTH ISSUES
Father					
Mother					
Brothers					
Sisters					

Hospitalizations and Surgeries

Year	Hospital	Reason for Hospitalization and outcome

Health Habits

Check (✓) which substances you use and describe how much you use.

	Alcohol	
	Tobacco	
	Exercise	

Medications

List medications you are currently taking, including over the counter medicines and supplements.

Pharmacy Name _____

Allergies

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Patient Signature

_____ Date

_____ Physician Signature

_____ Date