VEIN CENTER OF VENTURA

168 North Brent St. #508 Ventura, CA 93003

Patient Venous and Medical History Information

Patient Name: _____ Date of birth: _____

Primary Physician: _____ Referred by: _____

Reason for Referral: _____

Venous History

Reason you are seeking treatment for your veins: Medical _____ Cosmetic _____

How long have these veins been present/bothering you? _____ Are they getting worse? _____

Are you experiencing any of the following symptoms? Which Leg? [ ] RT [ ] LT [ ] BOTH

[ ] pain [ ] aching [ ] cramping [ ] heaviness in legs [ ] weakness [ ] swelling [ ] numbness

[ ] itching [ ] skin ulceration/bleeding [ ] burning [ ] throbbing [ ] other _____

Do the following things aggravate your veins?

[ ] walking [ ] exercising [ ] prolonged standing [ ] prolonged sitting [ ] sleeping

Do any of the following help your symptoms?

[ ] rest [ ] leg elevation [ ] stretching [ ] walking [ ] sitting [ ] medications
--if yes, what medications have you tried? _____

Have you ever worn compression hose? _____ For how long? _____ Did it help? _____

Have you had any of the following treatment(s) on your legs? (if yes, please give details below)
[ ] Sclerotherapy [ ] Phlebectomies [ ] Endovenous Laser [ ] Radiofrequency Ablation

[ ] Stripping/Ligation [ ] other _____

_____

Have you ever been treated for a blood clot in your leg? _____ When and which leg? _____

Have you had any Ultrasounds or other Radiology exams on your legs? If so, where/when?

_____

Surgical History Please list all operations below, and significant complications related to the operations:

Operation: Date:

_____

_____

_____

_____

Social History

Marital Status: _____Who do you live with? _____

Do you smoke? [] yes [] no [] quit If yes, for how long? _____ how many packs per day? _____

Are you a former smoker? [] yes [] no If yes, for how long? _____ how many packs per day? _____

How long ago did you quit? _____

Do you drink alcohol? []yes []no []quit If yes, how many per day? _____ If you quit, how long ago? _____

Do you have a history of substance abuse or IV drug use? _____

Do you have difficulty with any of the following?

[ ] Hearing [ ] Seeing [ ] Concentrating [ ] Remembering [ ] Making Decisions
[ ] Climbing Stairs [ ] Dressing [ ] Bathing [ ] Doing errands alone

Have you completed a "Durable Power of Attorney for Healthcare" also known as an "Advanced Directive" or a "Living Will"? [] yes [] no -if yes, please provide our office with a copy for your medical records.

Family History

Mother: [] Living [] Deceased If deceased, at what age? _____ Cause of death? _____

Father: [] Living [] Deceased If deceased, at what age? _____ Cause of death? _____

Brothers: Number living: ___ Number Deceased: ___ if deceased, at what age? _____Cause? _____

Sisters: Number living: ___ Number Deceased: ___ if deceased, at what age? _____ Cause? _____

Children: Number living: ___ Number Deceased: ___ if deceased, at what age? ____ Cause? _____

Check any conditions/diseases which your immediate family has experienced:

[] bleeding disorders [] cancer [] coronary artery disease [] diabetes [] heart attack [] heart problems
[] high cholesterol [] hypertension [] kidney disease [] pulmonary disease [] seizures/epilepsy
[] stroke [] sudden cardiac death [] tuberculosis [] varicose veins Other: _____

Medical History -- Please check all serious medical conditions for which **you** have been treated.

[] Aortic Aneurysm [] Aortic Valve Disorder [] Arrhythmia []Asthma [] **Cancer*** [] Cardiomyopathy
[] Congenital Heart Disease [] Congestive Heart Failure [] COPD [] Coronary Artery Disease [] CVA
[] Depression [] Deep Vein Thrombosis [] **Diabetes**** [] Gastrointestinal disease [] Genitourinary disease
[] Headaches/Migraines [] Heart Attack [] Hematologic disease [] Hyperlipidemia [] Hypertension
[] Kidney disease [] Liver disease [] Mitral Valve Disorder [] Neurologic disorder [] Pacemaker
[] Peripheral Arterial Disease [] Stroke [] Thyroid Problems [] Warfarin(Coumadin) Management

*** If history of Cancer, please give details (body part, how it was treated and dates):**

_____

** **If Diabetic,** controlled by: _____ insulin ____other medication ____diet Other:_____

Review of Symptoms — Please circle any conditions or symptoms you are currently experiencing or have recently experienced

Constitutional: Fever, night sweats, weight change (+/- ____ lbs), exercise intolerance

Eyes: Dry eyes, irritation, vision changes

Ears: Difficulty hearing, ear pain

Nose: Frequent nosebleeds, nose/sinus problems, runny nose, sinus pressure

Mouth/Throat: Sore throat, bleeding gums, snoring, dry mouth, oral abnormalities, mouth ulcer, Teeth abnormalities, mouth breathing

Cardiovascular: Chest pain, chest pain on exertion, arm pain on exertion, light headed on standing, shortness of breath when walking, shortness of breath when lying down, palpitations, heart murmur,

Respiratory: Cough, wheezing, shortness of breath, coughing up blood, sleep apnea

Gastrointestinal: Abdominal pain, vomiting, change in appetite, black stools, frequent diarrhea

Genitourinary: Urinary loss of control, difficulty urinating, increased urinary frequency, hematuria incomplete emptying

Musculoskeletal: Muscle aches, muscle weakness, arthritis/joint pain, back pain, swelling in the extremities

Skin: Jaundice, rash, hives, itching, dry skin, growth/lesions

Neurologic: Loss of Consciousness, weakness, numbness, seizures, dizziness, migraines, frequent or severe headaches, restless legs

Psychiatric: Depression, sleep disturbances, restless sleep, alcohol abuse,

Endocrine: Fatigue, increased thirst, hair loss, increased hair growth, cold intolerance,

MEDICATION INFORMATION SHEET

Name _____ Date of Birth _____

Pharmacy name/address: _____

ALLERGIES: Please list any medications you are allergic to, and what your reaction to that medicine is (hives, itching, etc…)

_____

_____

MEDICATIONS: Please list any medications you are taking (including over the counter drugs) with the strength and frequency.

Medication	Dose	Frequency