GVS Georgia Vein Specialists

PATIENT MEDICAL HISTORY

Last Name	First	MI

Age	Sex ☐ Male ☐ Female	Occupation

Were you referred by your physician? ☐ Yes ☐ No	Referring/Primary Physician (must include First and Last name)

SYMPTOMS: (please check all that apply)

	Right Leg	Left Leg		Right Leg	Left Leg
☐ Pain/Aching in Leg	☐	☐	☐ Itching/Burning	☐	☐
☐ Leg Cramps	☐	☐	☐ Ulcers/ Ulceration	☐	☐
☐ Skin Changes	☐	☐	☐ Leg/Restlessness	☐	☐
☐ Throbbing	☐	☐	☐ Tiredness/Fatigue	☐	☐
☐ Swelling	☐	☐			

Additional Comments: _____

Do you take any medications to relieve your symptoms? Yes ☐ No ☐	Please list any medication that you take to relieve your symptoms:

Are your symptoms worse with: ☐ Prolonged standing/sitting ☐ Menstrual cycle ☐ N/A	Are you symptoms relieved with? ☐ Rest ☐ Elevation of leg ☐ N/A

How many years have you had this/these symptoms?	Have you worn support or compression hose? ☐ Yes ☐ No	If yes, how long? ☐ 1-3 months ☐ 3-6 months ☐ > 6 months

What made you decide to seek treatment at this time?

Additional comments about your symptoms

FEMALES ONLY ☐ My symptoms are worse before or during menstrual cycle ☐ I am pregnant or actively trying to become pregnant ☐ I am on hormone therapy (i.e. estrogen, premarin, provera, birth control, etc.)	Number of pregnancies?	Number of deliveries?

Please list any allergies that you have:	Please list all medications that you are currently taking, including non-prescription:

Do you have any family history of varicose veins/spider veins? (please check all that apply)

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Have you had any previous vein treatment therapy? (please check all that apply) ☐ Vein Surgery ☐ Injections ☐ Laser ☐ Vein Evaluations ☐ Other _____	Where did you have your vein treatment?

MEDICAL HISTORY (please check all that apply)

☐ No History	☐ Leg Ulcer	☐ Stroke	☐ Seizures	☐ Other _____
☐ Blood Clots - Leg	☐ Leg Swelling	☐ Diabetes	☐ Cancer	
☐ Blood Clots - Lung	☐ High Blood Pressure	☐ Asthma	☐ Hepatitis	
☐ Leg Injury	☐ Heart Disease	☐ Bleeding Disorder	☐ HIV (AIDS)	

Have you ever been hospitalized for any of these conditions? ☐ Yes ☐ No If yes, please explain: _____

Patient Signature	Date