

CONFIDENTIAL MEDICAL HISTORY FORM

Name: _____ Today's Date: _____

Date of Birth: _____ Height: _____ Weight: _____ Gender: M F

1. When did you first notice your spider veins? _____

2. Do you have any bulging (protruding) varicose veins? Yes No

3. Have you seen another physician for your veins? Yes No

If yes, who? _____ When? _____

What treatment/testing was recommended? _____

Was the treatment/testing done? Yes No

4. Women: Are you pregnant or planning a pregnancy soon? Yes No

5. Leg Symptoms: Please check if you are currently suffering from any of the following:

Aching

Itching

Swelling

Throbbing

Numbness or Tingling

Leg Restlessness

Burning

Fullness or Pressure

Muscle Cramping

6. Illnesses or conditions for which you are currently under a doctor's care:

7. Previous operations including hysterectomy and cosmetic surgery:

8. Current medications and dosages: Prescription and non-prescription, including birth-control pills, aspirin, herbs, and vitamins:

9. Allergies: Medication or other: _____

Patient Signature

Physician Signature