Medical Questionnaire

Date: _____ Social Security: _____ Date of Birth: _____
Name: _____ Patient Account #: _____
Address: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Gender: _____ Age: _____ Height: _____ Weight: _____
BP: _____ HR: _____ Temp: _____ Pain Level: _____
Primary Care Physician: _____ Phone Number: _____
Place of Employment: _____ Phone Number: _____
Occupation: _____ Phone Number: _____
Emergency Contact: _____ Relationship: _____ Phone Number: _____
Pharmacy Name: _____ Phone Number: _____

How did you hear about the Vein Centre? (please check all that apply)

- □ Physician (if so, whom may we thank?) _____
- □ Friend (If so, whom may we thank?) _____
- □ TV (channel 2, channel 4 or channel 5?)
- □ Website (veinreliever.com)
- □ Social Media (Instagram, Facebook, Twitter, Youtube)

1. How long have you been having problems with your veins? _____

2. Please Check the Box(s) that describe any symptoms you have been having.

☐ Tired/Heavy Sensations	☐ Bleeding	☐ Phlebitis
☐ Aching Legs	☐ Burning Pain	☐ Pain in Legs w/ exercise
☐ Throbbing/Cramping Pain	☐ Skin Changes	☐ Swelling (Legs or Ankles)
☐ Skin Ulcers	☐ Numbness	☐Pain in Legs while resting
☐ Itching	☐ Tingling	☐ Skin discoloration
☐ Any symptoms NOT listed above →		

3. Alleviating factors? (circle all that apply):
Sitting – Surgery – Rest - Weight loss – Elevation – Compression - OTC medication

4. How does it affect your daily life?
_____

5. Have your veins become worse in the past several months? _____

6. Insurance requires 3 months of support hose use. Have you worn support hose? _____
If so, for how long? _____

7. Have you taken any analgesic medication for the pain? _____

8. Have you ever been treated for vein problems? _____
If yes, by whom, when and where: _____

9. Do you have a **family** history of vein symptoms (varicose veins, spider veins, leg ulcers, blood clots or swollen legs?) _____
   a. If yes, who? _____

10. Do you have a **personal** history of the following? (Check all that apply)

☐ Blood Clots/Phlebitis	☐ Thyroid	☐ High Blood Pressure
☐ Diabetes	☐ Asthma	☐ Fainting/Dizziness
☐ Stroke	☐ Vascular Disease	☐ Heart Disease
☐ Seizures	☐ Hepatitis	☐Migraines/Headaches

11. Do you have a **family** history of blood clots or phlebitis? _____

12. Please list all allergies: _____
    _____

13. List all medications that you are **currently** taking: (include birth control pills/hormones, blood thinners)
    _____
    _____

14. When was your last menstrual period? _____

15. Number of Pregnancies: _____

16. Do you use tobacco? (includes snuff, cigars, cigarettes, etc.)
    Yes: _____ How much: _____
    Not Currently: _____ When/How much? _____
    Never _____
    Do you use Alcohol? If so, How much and How often? _____

17. Please list all previous surgeries: _____
    _____
    _____

Patient Signature _____ Date: _____

Physician Signature _____ Date: _____