

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

Does prolonged sitting or standing aggravate your veins: _____ Are they getting worse? _____

Have you ever had treatment for your veins? _____ if so, when, where and what type of treatment?

Do your legs ever: Swell? _____ Ache? _____ Get red and inflamed? _____

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

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

Diagnostic Tests —List any recent diagnostic tests, including angiograms, ultrasounds, or x-rays of your legs:

Name of test/xray:

Date:

Where Performed:

Social History

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

If you quit, how long ago? _____

Do you drink alcohol? yes no quit If yes, how many drinks per day? _____

If you quit, how long ago? _____

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

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.

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

Operation:

Date:

Significant Complication:

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 father, mother, brothers, sisters, or children have 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
 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 _____

** If Diabetic, controlled by: _____ insulin _____ other medication _____ diet

Other: _____

Review of Symptoms —Please circle any conditions or symptoms you have 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,

