Capitol Vein & Laser Center
Patient Health History Form

Have you ever had any of the following?

An injury to either of your legs that required an operation or casting?

A deep vein thrombosis or blood clot in your leg?

Phlebitis?

A venous stasis ulceration or non-healing wound?

Hemorrhage from a varicose vein?

Sclerotherapy?

Vein Stripping?

Other Vein procedures?

***** Please answer the following very carefully as it will help your insurance company decide if your vein problems are a covered benefit.**

In the last six months have you…

Tried support stockings to relieve discomfort or swelling in your legs?

Taken pain medication because of discomfort in your legs?

Ever had to change or limit your lifestyle or activities due to discomfort in your legs?

Please indicate if you have any of the following:
Diabetes
Heart Disease
Lung Disease
Hypertension
Arthritis
Cancer
Seizures
Renal failure
Hepatitis
HIV Infection

Fainting
Anxiety
Tobacco Use

(For Women:)
Are you currently pregnant?
Are you currently breast feeding?

Are you currently (or recently) taking any of the following:
Lovenox
Coumadin (Warfarin)
Plavix
Daily Aspirin
Steroids
Antibiotics

Family History:
Please indicate if any of the following were present in your immediate family members:

Varicose Veins
Deep Vein Thrombosis (DVT)
Venous ulcers/ leg ulcers
Phlebitis
A history of Vein Surgery
Blood clots

Surgical History:
Please list the type and date of surgeries:
____
____
____
____

Have you ever been hospitalized for anything NOT mentioned above?
If so, for what reason were you hospitalized and when?
____
____

Review of Systems:

Do you currently have any of the following? If "yes", please explain on the following line.

Constitutional: Fevers, chills, recent unexplained loss of appetite or weight?

Eyes: Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting?

ENT: No recent change in hearing ability, discharge ,sore throat, dizziness or ringing in ears?

Cardiac: No chest pain, shortness of breath, waking from sleep breathless?

Respiratory: No shortness of breath, productive cough, coughing up blood or pain with breathing?

Gastrointestinal: No change in bowel habits, no black, red or bloody stools, vomiting or belly pain?

Genitourinary: No incontinence, frequent, urgent or painful urination? No blood in urine?

Musculoskeletal: No change in walking ability or strength. No painful joints?

Skin: No problematic rashes or itching, no changes in skin color or sores that won't heal?

Neurological: No unexpected, unexplained numbness, tingling or loss of memory or movement?

Psychiatric: No suicidal thoughts or hallucinations?

CVL
Capitol Vein & Laser Centers
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