

MEDICAL HISTORY

<p>Name.....Date.....</p>	<p>Please indicate type of symptoms you experience, pattern, duration, site and the leg(s) affected?</p>
<p>When did you first notice the condition ?</p>	<p>-pain or aching.....</p>
<p>.....</p>	<p>-heaviness.....</p>
<p>.....</p>	<p>-tiredness.....</p>
<p>Have you had treatment for varicose or spider veins in the past ?</p>	<p>-swelling.....</p>
<p>.....</p>	<p>-burning sensation.....</p>
<p>Surgery ?.....</p>	<p>-throbbing.....</p>
<p>.....</p>	<p>-itching.....</p>
<p>.....</p>	<p>-other.....</p>
<p>.....</p>	<p>If you experience symptoms, are they aggravated by ?</p>
<p>Injections ?.....</p>	<p>-standing/sitting for long periods.....</p>
<p>.....</p>	<p>-climbing stairs.....</p>
<p>Laser ?.....</p>	<p>-heat.....</p>
<p>.....</p>	<p>-menstruation.....</p>
<p>Which leg and what location was treated ?.....</p>	<p>-walking or exercising.....</p>
<p>.....</p>	<p>-inactivity.....</p>
<p>.....</p>	<p>-other.....</p>
<p>When ?.....</p>	<p>Do you obtain relief from symptoms with any of the following ?</p>
<p>By whom ?.....</p>	<p>-rest.....</p>
<p>.....</p>	<p>-walking or exercising.....</p>
<p>How do you rate the treatment so far ?.....</p>	<p>-leg elevation.....</p>
<p>.....</p>	<p>-wearing support hose.....</p>
<p>.....</p>	<p>-medication.....</p>
<p>.....</p>	<p>-other.....</p>
<p>Family history of varicose/spider veins ? Provide details.</p>	<p>Please list the medications you are taking at present ?</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>Do you have any indication of exposure to the AIDS or Hepatitis virus ?.....</p>
<p>.....</p>	<p>.....</p>
<p>Please indicate:</p>	<p>Do you suffer from any allergies ?.....</p>
<p># of full term pregnancies.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p># of abortions/miscarriages.....</p>	<p>Please provide any further information you feel might be helpful in your treatment.....</p>
<p>.....</p>	<p>.....</p>
<p>Please describe how the pregnancy has affected your varicose veins ?.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>Please list past hospitalizations for surgery or serious illnesses? In particular is there any history of phlebitis or a swollen leg ?.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>.....</p>	<p>.....</p>
<p>Present health.....</p>	<p>Thank you.</p>