



6585 Rochester Road
Suite 103
Troy, MI 48085
(248) 720-2544



44720 Hayes Road
Suite 200
Clinton Twp, MI 48038
(248) 416-5555

CONFIDENTIAL HEALTH HISTORY PATIENT INFORMATION

PLEASE PRINT LEGIBLY.

Name: _____ Date: _____
 Patient's DOB: _____ Patient's Age: _____ Sex: Male Female
 Family Physician: _____ City: _____
 Referring Physician: _____ City: _____

PRESENT SYMPTOMS

Do your legs or ankles suffer from any of the following?:

- | | | | |
|---|--------------------------------|-------------------------------|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Right | <input type="checkbox"/> Left | [____: Rate on a scale of 1-10, 10 being the worst] |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Right | <input type="checkbox"/> Left | [____: Rate on a scale of 1-10, 10 being the worst] |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Pulsating/Throbbing | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Tender to touch | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Skin changes/discolor | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Varicose/Spider veins | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Bleeding from varicose | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Right | <input type="checkbox"/> Left | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Right | <input type="checkbox"/> Left | [_____] |

When do you notice symptoms?

- Standing During evening Sitting Resting

When did you first notice symptoms? _____

Have the symptoms become worse? Yes No _____

For FEMALE patients:

- Did pregnancy aggravate symptoms? Yes No
 Family history of still births? Yes No

VENOUS MEDICAL HISTORY

Current Symptoms:

Do YOU have a history of (check all that apply):

- Deep Vein Thrombosis (DVT)
 Blood clot in the lungs



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- Superficial Phlebitis
 - Injuries to your leg(s) or veins
 - Family history of varicose veins
 - Family history of DVT, stroke or clotting disorders
 - Occupation requiring long periods of standing/exertion
 - Mother
 - Father
 - Grandparents
 - Mother
 - Father
 - Grandparents
- Occupation: _____

Treatment of Your Symptoms of Venous Disease

- Have you been treated for your veins before? Yes No
- If yes, by whom? _____ When? _____
- What method of treatment was used? Laser Radiofrequency closure
- Sclerotherapy Stripping Other _____
- What have been your results: _____

- Have you worn compression medical hose for conservative relief? Yes No
- If yes, how long? _____
- Are you on your feet for long periods? Yes No
- If yes, what capacity? _____
- Does walking/exercise relieve your discomfort or make it worse? Relieves Worsens

Do you have a history of any of the following (check all that apply):

- Varicose or spider vein treatment
- Venous ulcer treatment
- Bleeding from varicose veins
- Wearing compression stockings What mm? _____
- Taking anti-inflammatory medication for your legs
- Rest and elevation of legs to reduce symptoms
- Exercise to reduce symptoms How often: _____
- Weight loss to reduce symptoms # lbs: _____ over # of years: _____

For FEMALE patients:

- Currently pregnant
- Planning on future pregnancy
- Problems during pregnancy _____

PAST MEDICAL HISTORY (check all that apply):

Do YOU have a history of:

- Kidney/Bladder Disease
- Diabetes; Insulin dependent
- Peripheral Vascular Disease
- Heart Valve Problems
- Pulmonary Embolus
- Atherosclerosis
- Blood Transfusion(Date) _____
- Cancer of _____
- Liver Disease
- Hepatitis
- HIV/AIDS
- Thyroid Disease
- Stroke
- TIA D Coronary Heart Disease
- Bleeding or Blood Disorder
- Anemia
- Easy Bruising
- High Blood Pressure
- Carotid Disease
- Rupture of a vein
- Trauma to your legs



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Other: _____

Do you have any allergies or sensitivities to medicines or tape? List all: _____

PAST SURGICAL HISTORY (Include year of procedure) (attach additional sheet if necessary)

BLEEDING HISTORY (Please check all that apply)

- Excessive Bleeding Easy Bruising Aspirin Use
 Coumadin Use
 Other: _____

SOCIAL HISTORY (Please check all that apply)

- Smoke _____ packs per day for _____ years
 Alcohol use: _____ None _ Social _# years

Occupation: _____

Marital Status: Married Single Divorced Widowed

Children(Ages -if under age 25): _____

FAMILY HISTORY (Please check all that apply)

- Family history of *heart disease*: Mother Father Grandparents Sibling
 Family history of *hypertension*: Mother Father Grandparents Sibling
 Family history of *diabetes*: Mother Father Grandparents Sibling
 Family history of *cancer*: Mother Father Grandparents Sibling
 Family history of *strokes*: Mother Father Grandparents Sibling

CURRENT MEDICAL INFORMATION

Are you being treated for any current medical conditions? Y / N If so, what are these conditions? (attach separate sheet if necessary)

Please list all medicines that you take (Prescription, Non-Prescription Vitamins and Herbal):



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REVIEW OF SYSTEMS (Please Check all that apply)

- Constitution:* Weight loss Weight gain Night sweats Fever
- Skin:* Change in size/color of moles Rash Bruising
- Eyes:* Decreased vision Double vision Blurred vision Glasses
- ENMT:* Pain Deafness Discharge Ringing in ears Sinus drainage
- Nose bleed Hoarseness
- Cardiac:* Palpitations Chest pain Shortness of breath Fatigue Swelling in feet/legs
- Respiratory:* Cough Production of sputum Coughing of blood Pain
- Gastro:* Painful swallowing Nausea Vomiting Vomit blood
- Indigestion* Diarrhea Constipation Tarry stools Yellow jaundice
- Bloody stools Change in BMs
- Genito:* Kidney/bladder disease Decreased urine stream
- Unable to urinate Painful urination Blood in urine
- Musc/Skel:* Weaknes Trauma Limited motion Bone/joint deformity
- Neuro:* Paralysis Weakness Seizure Fainting
- Headache Migraine Incoordination Head trauma
- Numbness/tingling in extremities
- Psych:* Anxiety Depression Hallucinations
- Endocrine:* Change of appetite Excessive thirst/urination Goiter
- Hemato:* Swollen lymph nodes Bleeding disorders
- Immuno:* Immune disorders Immunosuppression

[FEMALES ONLY:]

- Breast:* Lumps Pain Nipple discharge Infection
- Trauma Last mammogram(date) _____
- Gyn:* rregular periods Hormone therapy Menopause
- Last pelvic exam (date) _____ Last period(date) _____

Signature: _____ Date: _____