THE VEIN INSTITUTE AT
RHODE ISLAND **MEDICAL IMAGING**®

Patient Health History Form

Please answer all the following questions, trying not to leave any blank.

Name: _____ Telephone Number:_____

Date of Birth: _____ Date of Visit:_____

Sex: Male / Female Height: _____ Weight: _____

What is your Primary Care Physician's name? _____

What is the name & phone number of your pharmacy?_____

Please list all current medications (prescription & non-prescription):

Medication:	Dosage:	How often do you take it?	Pill or Shot?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any Allergies? ❑ Yes ❑ No If so, to what? _____

Are you allergic to Latex? ❑ Yes ❑ No

Past Medical History (Please circle)

Hypertension	Y / N	Cancer	Y / N	Diabetes	Y / N
High cholesterol	Y / N	Heart disease	Y / N	Stroke	Y / N
Lung disease	Y / N	Kidney failure	Y / N	Anemia	Y / N
Leg ulcer	Y / N	Heart murmur	Y / N	Blood Clots	Y / N
Pregnancy	Y / N	HIV/AIDS	Y / N	Hepatitis	Y / N

If you have diabetes, have you had a dilated eye exam in the last 12 months? ❑ Yes ❑ No

If so, which month? _____

Prior Surgical History: (please list):

_____

_____

Family History

(It is important for us to know your family medical history. Please include if any family member has experienced varicose veins, spider veins, leg ulcers, congestive heart failure, and coronary artery disease or had bypass surgery.)

Mother ❑ Alive ❑ Deceased Age: _____ Ailments: _____

Father ❑ Alive ❑ Deceased Age: _____ Ailments: _____

Brothers # _____ Age: _____ Ailments: _____

Sisters # _____ Age: _____ Ailments: _____

Children # _____ Age: _____ Ailments: _____

Social History:

Tobacco use: Y / N Recreational Drugs: Y / N Alcohol: Y / N Married: Y / N

If positive for tobacco use, document smoking cessation counseling _____

Review of Systems: (Please circle)

Vision changes	Y / N	Shortness of breath	Y / N	Currently pregnant	Y / N
Headaches	Y / N	Stomach pain	Y / N	Urinary frequency	Y / N
Chest pain	Y / N	Nausea	Y / N	Diarrhea	Y / N
Sore throat	Y / N	Joint pain	Y / N		
Fever	Y / N	Currently breastfeeding	Y / N		

Vein History

Which leg is the most bothersome to you? ❑ Right ❑ Left ❑ Equal

Do you have moderate to severe pain that causes functional or physical impairment on your legs? Y / N

If you answered Yes, which leg, R / L or Both

Have you ever had your veins evaluated before? Y / N

If so, what doctor and when? _____

Did this doctor perform any tests on your veins? (example: Ultrasound) Y / N

Have you ever had any vein surgery or injections? Y / N

Do you experience any of the following symptoms on your leg(s)?

Aching/pain in your legs	Y / N	Restless Legs	Y / N	Leg Cramps	Y / N
Tiredness/fatigue	Y / N	Heaviness	Y / N	Throbbing	Y / N
Swollen ankles	Y / N	Itching/burning	Y / N	Bleeding Episodes	Y / N

How long have you experienced these symptoms? Months:_____ Years: _____

Do your daily activities require prolonged periods of standing? Y / N

If yes, please list activities _____

How many times a day do you have to sit or take a break due to leg pain? _____

What daily activities were you previously able to do at work or home that you can no longer perform?

Please be specific_____

_____

_____

Do you take over the counter medications (e.g. aspirin, ibuprofen) for leg pain? Y / N

If yes, what medication / doses_____

How often do you take these medications per week? (please circle)

0-2 days 3-4 days > 5 days

Have you worn compression stockings for at least (please circle)

2 weeks 6 weeks 3 months 6 months

If yes, do they provide relief? Y / N

For female patients only

Do you experience pelvic discomfort/heaviness? Y / N

Do you experience discomfort/pain during intercourse? Y / N

Do your pain symptoms worsen during menstruation? Y / N

Disclaimer: To the best of my knowledge the information that I completed on this form is accurate as of this date and I am aware that this may change once I speak with my physician.