RHODE ISLAND VASCULAR INSTITUTE

Patient Health History Form

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

(This will assist our office in assessing your particular needs for proper medical care. Also, due to the insurance industry's need to fully understand your medical needs it is necessary to complete as much of this form as necessary.)

Name: ______________________________ Date of Visit: ______________________

Date of Birth: ________________________ Age: __________ Sex: Male / Female

Height: _______________ Weight: ____________

Past Medical History

1) Have you ever been in the hospital as a patient? Yes No
If yes, specify when and for what reason. ____________________________________
____

2) Have you ever had surgery of any kind? Yes No
If yes, please specify when and what type of surgery.
____
____

Vein History

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

2) Have you ever had your veins evaluated before? Yes No
If so, what doctor and when? _______________________________________
Did this doctor perform any tests on your veins? (example: Ultrasound)

3) Do you wear support hose prescribed by a doctor? Yes No
Is yes, what type and do they provide relief? Yes No

4) Do you wear light support hose (example: sheer energy) Yes No
If so, do they provide relief? Yes No

5) Have you ever had any vein surgery? (stripping or sclero) Yes No
If yes, what leg? Right Left

6) Have you ever had vein injections? Yes No

If yes, what leg? Right Left

7) Have you ever had any blood clots? Yes No

If yes, what leg? Right Left

8) Have you ever had phlebitis? Yes No
If yes, what leg? Right Left

9) Do you experience any of the following symptoms?

Aching/pain in your legs	Yes	No	Heaviness	Yes	No
Tiredness/fatigue	Yes	No	Itching/burning	Yes	No
Swollen ankles	Yes	No	Leg Cramps	Yes	No
Restless Legs	Yes	No	Throbbing	Yes	No

Any other symptoms?___________________________________

10) How long have you experienced these symptoms? Months:_____Years:______

11) Does walking help the discomfort? Yes No

12) Do you stand much at work? Yes No How long?____________
Do you stand much at home? Yes No How long?____________

13) How do you relieve the discomfort in your legs? Elevate Walk

Current Medical History

14) Do you have:

		Medications?			Medications?
Heart Disease	Yes	No____________	Pacemaker	Yes	No____________
Lung disease	Yes	No____________	Anemia	Yes	No____________
Hepatitis	Yes	No____________	Arthritis	Yes	No____________
Leg Ulcer	Yes	No____________	Diabetes	Yes	No____________
Asthma	Yes	No____________	Thyroid	Yes	No____________
High Blood pressure	Yes	No____________			

15) Are you presently under the care of a physician Yes No
If yes, please indicate who and for what illness or purpose:_________________
____
____
____

What is you Primary Care Physician's name?
____

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

Medication:	Dosage:	How often do you take it?
____________________	_______________	_________________________
____________________	_______________	_________________________
____________________	_______________	_________________________
____________________	_______________	_________________________

Do you take blood-thinning medications? Yes No_____________________

Do you take birth control pills or hormones? Yes No_____________________

17) Do you have any allergies?
(example: medicine, food or pollen)

____
____
____

Describe how they affect you:
(example: rash, hives, shortness of breath)

____
____
____

Are you allergic to Latex? Yes No

*Any allergies to shrimp or shellfish or any other form of iodine, IVP dye? Yes No

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, 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

What is your profession? ____
Do you smoke? If yes, how much? ____
Do you drink alcohol? If yes, how much? ____

Women Only: Child Bearing History

1) Do you think you are presently pregnant? Yes No
2) How many times have you been pregnant? _________
3) Do you intend to have any more children? Yes No
4) Are you currently breast-feeding? Yes No
5) What is the name of your OB/GYN physician?

____