VEIN MEMPHIS
SUSHMA PAREKH, M.D.

Patient Health History

Patient Name: _____ Date: _____

Address: _____ Phone Number: _____

Past Medical History: (Please check all that apply)

	Anemia		Fibromyalgia		Migraines
	Anxiety		Hearing Loss		Mitral Valve Prolapse
	Aortic Aneurism		Heart Disease		Pacemaker
	Cancer		Hepatitis		Pulmonary Embolus
	Chronic Pain		High Cholesterol		Prosthetic Heart Valves
	Depression		HIV		Seizures
	Diabetes		Hypertension		Stroke
	Difficulty Walking		Lupus		Shortness of Breath
	Fever Blisters/Cold Sores		Lymphedema		Thyroid Problem

Females Only: *How many pregnancies have you had? _____ What is the total number of births to date? _____*

Are you currently pregnant or planning pregnancy in the near future?	YES	NO
Are you currently breast feeding	YES	NO
Are you taking hormone therapy or replacement?	YES	NO
Are you using contraceptives to prevent pregnancy?	YES	NO
Are you post-menopausal?	YES	NO
During menstruation, are/were your symptoms of leg pain exacerbated?	YES	NO

Surgical History: (please include elective surgery)

(Procedure)	(Year)	(Doctor/Hospital)	(Complications?)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal and Family Vein History: Please check all that apply

	Patient	Mother	Father	Sibling	Aunt/Uncle	Grandparent
Varicose Veins						
Spider Veins						
Stripping Procedures						
Deep Vein Blood Clots						
Superficial Blood Clots						
Stroke						
Leg Ulcers						
Clotting Disorder						
Bleeding Disorder						
Cosmetic Vein Treatments						
Medical Vein Treatments						

Social History:

Have you ever smoked on a regular basis? **YES** **NO**

Do you currently smoke? **YES** **NO**

If yes, how many cigarettes do you smoke daily? _____

If yes, how many years have you smoked? _____

Do you have an interest in smoking cessation? **YES** **NO**

Do you drink alcohol? **YES** **NO**

Average number of drinks per week? _____

Inner Office Notes:

_____
_____
_____
_____

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Allergies: (include both medication and environmental allergies)

_____
_____
_____

Current Medications: *Include prescription and over-the-counter medications including vitamins and supplements.*

(Medication Name)	**(Dose)**	**(Reason You Are Taking?)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take a daily aspirin or any other blood thinning medications? **YES** **NO**

What is your current HEIGHT _____WEIGHT _____

Are you currently trying to lose weight? **YES** **NO**

Have you had a weight gain or weight loss in the last 3 months? **YES** **NO**

If yes, how many pounds? _____

The following questions relate to your leg health: Circle all that apply or when appropriate the best response.

The symptoms that I experience affect my: Left Leg Right Leg Both Legs

I would describe my symptoms as the following:	Pain Itching Fatigue Swelling Burning Heaviness Bleeding Aching Cramping Redness Restless Legs Spider Veins Varicose Veins
Severity of the Discomfort, I would rate:	(No Pain) (Severe) 0 1 2 3 4 5 6 7 8 9 10

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Symptoms affect these activities:	Sleep Normal Daily Activities Exercise Work House Work Child Care
Symptoms are worsened by these activities:	Sitting Standing Night Time Exercise Walking Pregnancy Premenstrual Heat
Symptoms are somewhat improved with the following:	Ice/Cool Packs Leg Elevation Weight Loss Pain Medication Heating Pad Exercise Soaking Legs Compression Hose Nothing

Have you ever had your veins evaluated before? **YES** **NO**

If yes, when and where? _____

Do you wear support hose or compression stockings? **YES** **NO**

If yes, do they provide relief? **YES** **NO**

Were they prescribed by a physician? **YES** **NO**

Have you had Sclerotherapy before? **YES** **NO**

If yes, do you know what medication was used? _____

Have you ever had an adverse reaction to any medications for Sclerotherapy **YES** **NO**

If yes, please describe reaction: _____

Is there any additional information you feel is helpful for us to know about your health or reason for visit? If so, please list below:

_____

_____

Inner Office Notes:

_____
_____
_____
_____