SCHNECK
VEIN CENTER

Name: _____

Date of Birth: _____

Patient Health History

Chief Complaint: Please circle if you have any of the following symptoms.

Leg pain | Leg swelling | Leg ulcer (sore that is hard to heal)

Recurrent superficial thrombophlebitis (inflammation of a vein with clot)

Varicose (bulging veins)

Additional Complaints: Please circle if you have any of the following symptoms.

Swelling	Restless legs	Leg cramping
Venous Stasis Ulcers	Itching of the legs	Heaviness of the legs
Redness	Aching of the legs	Leg tightness
Burning sensation	Bursting/bleeding of varicose veins	
History of blood clots	Pain requiring analgesics	

List any other symptoms you have in your legs: _____

_____

Do these symptoms limit your activities: YES NO

Are these symptoms affecting the following?

Trouble sleeping/awakens me from sleep YES NO

Prevents me from walking any distance YES NO

Affects my ability to care for myself YES NO

Affects my ability to perform my job duties YES NO

Who referred you: _____

ALLERGIES:

Please list anything you are allergic to below:

_____

_____

HEIGHT: _____ WEIGHT: _____

CURRENT MEDICATIONS:

Name	Dose (ex: mcg, mg, etc.)	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Please use the back of this page if additional space is needed

Have you experienced any of the following? Please circle:

Physical Abuse:	Current	History	None
Sexual Abuse:	Current	History	None
Emotional Abuse:	Current	History	None

YOUR PAST MEDICAL HISTORY:

Please circle if you have or have ever had any of the following:

Endocrine: Diabetes mellitus Grave's disease Hyperthyroidism Hypothyroidism
Other endocrine history: _____

Respiratory:
Allergies/hay fever Asthma COPD CPAP use Sleep apnea
Other respiratory history: _____

Cardiovascular:

Abdominal aortic aneurysm	Angina	Atrial fibrillation
Cardiac arrhythmias	Coronary artery disease	Deep venous thrombosis
Heart failure	Heart valve disease	Hyperlipidemia
Hypertension	Myocardial infarction	Peripheral vascular disease
Blood clot	Venous disease	Vein stripping

Other CV history: _____

Gastrointestinal:

Colitis	GERD	Irritable bowel syndrome	Liver disease
Pancreatitis	Peptic ulcer disease	Hiatal Hernia	

Other GI history: _____

Genitourinary:

Chlamydia	Gonorrhea	Hemodialysis	Herpes genitalis
Human papilloma virus	Kidney disease	Kidney failure	Kidney stones
Past UTI	Peritoneal dialysis	Urinary incontinence	

Other GU history: _____

Hematology/Oncology:

Anemia	Blood cancer	Brain cancer
Breast cancer	Cervical cancer	Coagulopathy
Colorectal cancer	Endocrine cancer	Eye cancer
GI cancer	GU cancer	Kidney cancer
Leukemia	Liver cancer	Lung cancer
Lymphoma	Musculoskeletal cancer	Myeloma
Neurologic cancer	Oral cancer	Ovarian cancer
Skin cancer	Stomach cancer	Thrombocytopenia

Thyroid cancer Uterine cancer
Other cancer history: _____
Other hematologic history: _____

Neurologic:

ADHD	Autism	Dementia
Developmental delay	Headaches	Multiple sclerosis
Parkinson Disease	Peripheral neuropathy	Restless leg syndrome
Seizures	Stroke	Transient ischemic attack

Other neurologic history: _____

Disabilities:

Hearing deficit	Vision deficit	Hemiparesis
Paraplegia	Quadriplegia	

Other disabilities: _____

PAST SURGICAL HISTORY:

Please circle if you have ever had any of the following.

HEENT:

Cataract extraction	Dental surgery	Laryngectomy	Tonsillectomy

Other head surgery: _____
Other eye surgery: _____
Other ear surgery: _____
Other nasal surgery: _____
Other throat surgery: _____

Endocrine:

Parathyroidectomy	Thyroid surgery

Other endocrine surgery: _____

Respiratory:

Bronchoscopy	Lobectomy

Other chest surgery: _____

Cardiovascular:

Angiogram	Angioplasty	CABG surgery	Carotid endarterectomy
Coronary stent	Heart transplant	Pacemaker	Valve replacement

Other cardiac surgery: _____

Gastrointestinal:

Appendectomy	Cholecystectomy/Gallbladder		Colectomy, subtotal
Colectomy, total	Hernia repair	Splenectomy	Bariatric Surgery

Nissen fundoplication
Other GI surgery: _____

Genitourinary:
Bladder surgery Kidney stone extraction Nephrectomy
Other GU surgery: _____

Gynecological – Female:
Cervical Conization/LEEP Hysterectomy Tubal Ligation Cesarean Delivery
Oophorectomy
Other Gynecologic (Female) surgery: _____

Genitourinary – Male:
Prostatectomy TURP Vasectomy
Other GU (Male) surgery: _____

Musculoskeletal:
Joint replacement
Other musculoskeletal surgery: _____

Integumentary:
Skin cancer removal
Other integumentary surgery: _____

Neurologic:
Craniotomy Spinal surgery
Other neurologic surgery: _____

Breast:
Breast biopsy Lumpectomy Mastectomy, bilateral
Mastectomy, left Mastectomy, right
Other breast surgery: _____

Other surgical history (not listed above):
_____

FAMILY MEDICAL HISTORY:

Do you have any siblings? Number of Brothers: _____ Number of Sisters: _____

Do you have any children? Number of Sons: _____ Number of Daughters: _____
Does anyone in your family (grandparents, parents, siblings, and/or children) have any of the following and if so please list which family member:

Venous Thrombosis: _____

Varicose Veins: _____

SOCIAL HISTORY:

Please circle/fill-in accordingly for the following:

Adopted: YES NO

Marital Status: _____

Do you live in a nursing home? YES NO

If yes, where? _____ For how long? _____

Occupation: _____

TOBACCO USE:

Please circle/fill-in accordingly for the following regarding tobacco use:

Never smoker | Current every day smoker | Current some day smoker

Light tobacco smoker | Former Smoker/Quit Date: _____ | Heavy tobacco smoker

How long have you smoked/did you smoke? _____

How many packs per day? _____

SMOKELESS TOBACCO USE

Dipping tobacco	Snuff	E-Cigarettes
Chewing tobacco	Tobacco Gum	Other: _____

ALCOHOL USE:

Please circle/fill-in accordingly for the following regarding alcohol use:

None 0-2 drinks per day 2+drinks per day Other:_____

RECREATIONAL DRUG USE:

Please circle/fill-in accordingly for the following regarding recreational drug use:

None	Marijuana	Cocaine/Crack
Amphetamines	Hallucinogens	Tranquilizers/sedatives
Opiates	Painkillers	Club/designer drugs
Inhalants	Injection drugs	

Other: _____

CONSERVATIVE TREATMENTS USED:

Please circle if you are currently doing or have done in the past any of the following (insurance requirements to meet medical necessity):

Compression Hose Elevate Feet/Legs Walk Regularly Failed attempts at Weightloss

Other: _____

CURRENT SYMPTOMS:

Please circle how your current pain feels:

Aching Burning Cramping Dull Intermittent Sharp None

Other: _____

PAIN HISTORY:

How Long Have You Had Pain in Your Legs: _____

Does your pain require analgesics regularly : NO YES – name of medication: _____

How would you rate your pain on the 0-10 Pain Scale (0=No Pain, 10=Most Pain): _____

PAIN MADE WORSE BY:

Heavy lifting Long car trips Standing Sitting

Other: _____

PAIN IMPROVED BY:

Analgesics Bed Rest Elevating extremities Compression Stockings

Other: _____

Do you get anxious, nervous, or uneasy around needles or during medical procedures? (Please circle) YES NO

If yes, how would you rate your anxiety? (Please circle) LOW MODERATE HIGH

1. if you have any questions prior to your scheduled appointment.