TALLAHASSEE VEIN & FACE CLINIC

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Last Name **First Name** **MI**

Medical History

Please answer the following questions to the best of your ability. You may estimate dates of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery?
   - □ yes □ no
   - If so, which leg, and when? _____
2. Have you ever had vein injections?
   - □ yes □ no
   - If so, which leg, and when? _____
3. Have you ever had a blood clot?
   - □ yes □ no
   - If so, which leg, and when? _____
4. Have you ever had painful, inflamed veins (phlebitis)?
   - □ yes □ no
5. Do you have a history of the following conditions? (check all that apply)

□ Blood Clots	□ Cancer	□ Depression	□ Defibrillator
□ Diabetes	□ Dialysis Shunt	□ Easy Bruising	□ Fibromyalgia
□ Heart Disease	□ Hemophilia	□ Hepatitis A, B, or C	□ High Blood Pressure
□ HIV Positive	□ Keloid Scars	□ Latex Allergy	□ Lupus
□ Pacemaker	□ Pregnancy	□ Seizures	□ Shingles
□ Smoking	□ Other (please specify) _____		

6. Do you experience any of the following in your legs?

	Right Leg	Left Leg	Both Legs	Neither
Aching/Pain	□	□	□	□
Heaviness	□	□	□	□
Tiredness/Fatigue	□	□	□	□
Itching/Burning	□	□	□	□
Swollen Ankles	□	□	□	□
Leg Cramps	□	□	□	□
Restless Legs	□	□	□	□
Throbbing	□	□	□	□

7. Have your leg symptoms gotten worse recently?
   - □ yes □ no
   - If so, how? _____
8. Do you take medication for pain?
   - □ Advil □ Tylenol □ Motrin □ Other (please specify) _____
9. Do you prop up your legs to relieve discomfort?
   - □ yes □ no
   - How long each day? _____
   - Does it relieve your symptoms? _____

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Medical History (cont.)

10. Do you exercise?
    □ yes □ no
11. What type of work do you do? _____
    How long do you stand at work? _____
    Do your symptoms interfere with your job requirements/duties?
    □ yes □ no
    How so? _____
12. Have you ever had testing done on your veins?
    □ yes □ no
    If so, which tests and when? _____
13. Have you been diagnosed with venous disease?
    □ yes □ no
14. Are you being treated for leg problems or for problem veins?
    □ yes □ no
    If so, by whom? _____

Family History

Does anyone in your family have (or did they have) "bad veins," leg ulcers, or swollen legs? (check all that apply)

□ Father □ Mother
□ Brother(s) □ Sister(s)
□ Other (please specify) _____

Allergies

□ I have no known allergies.

Name of Drug/Item	**Reaction**

Medications (Please include over-the-counter medications and vitamins/supplements.)

□ I am not currently on any medication

Name of Medication	**Dosage**	**Times Per Day**

_____ _____

Patient/Guardian Signature **Date**

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Patient Name: _____

Last Name **First Name** **MI**

For Physician Use Only

Do you feel this patient's symptoms are an interruption in day-to-day activities/responsibilities?

□ yes □ no

If so, how does it interfere with the patient's daily life?

_____

_____

_____

_____

_____

Has the patient worn compression hosiery?

□ yes □ no

If so, for how long? _____