MADISON VEIN CENTER
SHOALS VEIN CENTER
A DIVISION OF SHOALS SURGICAL GROUP, LLC
PERSONAL HISTORY

Patient's Name_____ DOB_____ Date_____

Referring Physician _____

Reason for Visit _____

Location_____ Severity (Scale 1-10) ____ Duration (How long)_____ Timing(When it Occurs)_____

SYMPTOMS/LEGS

__Aching / Pain
__Heaviness
__Tiredness/Fatigue
__Burning
__Itching
__Swelling
__Cramps
__Restless Legs
__Skin Changes
__Throbbing
__Ulcers
__Spider Veins
__Other_____

VASCULAR HISTORY

Do you have or have you ever been diagnosed with:
__Phlebitis(vein redness.tenderness)
__Blood Clots
__DVT
__Saphenous Vein Reflux
__Varicose vein problems

PAST SURGERIES

__Heart Surgery
__Vein Stripping
__Sclerotherapy
__Laser on Legs
__Electrosurgical

MEDICATIONS

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Drug **ALLERGIES**_____
_____

Food **ALLERGIES**_____

PAST MEDICAL HISTORY

__Arthritis	__COPD/Emphysema	__Gout	__Phelbitis	__Thyroid Disorder
__Asthma	__Diabetes	__Heart Failure	__Seizure Disorder	__Valvular Heart Disease
__Bleeding Disorder	__Dialysis	__High Blood Pressure	__Sinusitis	__Other_____
__Blood Clots	__DVT	__Migraines	__Stroke	_____

FAMILY HISTORY

__Bleeding Disorder
__Varicose Veins
__Blood Clots
__Stroke
__Heart Disease
__DVT
__Pulmonary Emboli
__Phlebitis

SOCIAL HISTORY

Tobacco: Cigarettes____/Day Cigars___/Day Quit Y N
Snuff_____ Chew_____ Quit Y N
Alcohol: Type_____Amount_____Years_____

Occupation_____

REVIEW OF SYSTEMS (Please Check All Symptoms You are Experiencing Now)

Constitutional	__Black Out Spell __Dizziness __Fatigue __Fever __Loss of Appetite __Weakness
HEENT	__Blurred Vision __Hearing Loss __Hoarseness __Ringing in Ears __Sore Throat __Vision Loss
Respiratory	__Bloody Phlegm/Sputum __Cough __Shortness of Breathing ___Wheezing
Cardiovascular	__Ankle Swelling __Chest Pain __Irregular Heartbeat __Leg Pain with Walking __Palpitations
Urinary Tract	__Blood in Urine __Burning on Urination __Frequency __Hesitation __Urgency/Incontinence
Male Only	__Prostate Problems __Impotence
Female Only	__Menstrual Problems __Abnormal Vaginal Bleeding __Menopausal Symptoms __Breast Lumps/Discharge
Musculoskeletal	__Joint Pain/Swelling __Joint Stiffness __Back Pain __Muscle Pain __Neck Problems
Skin	__Skin Lesions __Rash __Sores __Itching
Neurology	__Headaches __Muscle Weakness __Numbness
Psychiatric	__Agitation __Anxiety __Confusion __Depression __Difficulty Sleeping __Memory Loss
Endocrine	__Heat/Cold Intolerance __Excessive Thirst or Urination
Hematology/Lymph	__Excessive Bruising __Free Bleeding __Swollen Glands

_____ _____ _____Reviewed history recorded by patient
Patient Signature Date

Physician Signature_____