

The Vein Clinic of Santa Barbara

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

AREAS OF CONCERN

Varicose Veins Spider Veins

GENERAL HISTORY

Age: _____

Are You: Pregnant? Planning a Pregnancy? Nursing?

Medications: None Aspirin Plavix Coumadin NSAIDS Birth Control

Allergies: _____

Have You Ever Has **Any** Reaction to Latex _____ or Tape? _____

Have You Ever Had **Any** Reaction to a Local Anesthetic? _____

Have You Ever Had **Any** Reaction to Needle Sticks/Blood Draws, Etc? _____

Do you have a history of migraine headaches? Yes No

Do you have a heart murmur? Yes No

Previous Surgeries to Legs? _____

History Of: Lung Blood Clot Deep Vein Thrombosis Bleeding Disorder

HIV Hepatitis B/C Herpes None of the Above

VEIN HISTORY *PLEASE BE SURE TO COMPLETE ALL SECTIONS*

How many years have you had a problem with Varicose and/or Spider Veins? _____

SYMPTOMS: None Burning Itching Tingling Cramping Heaviness

Leg Fatigue Leg Rash Pain/Discomfort Ulcer Swelling

Other, Explain: _____

Do you have a family history of Varicose and/or Spider Veins? Yes No

Have you ever been treated for Varicose and/or Spider Veins? Yes No

If Yes, When? _____ By Whom? _____

What Method? Stripping Ligation Laser Sclerotherapy Electrocautery

Other: _____