



# Advanced Venous Solutions

500 NW 43rd Street, Suite 2 • Gainesville, FL 32607 • (352) 376-5112

## HEALTH HISTORY QUESTIONNAIRE

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

**CHIEF COMPLAINT AND HISTORY:** Please describe for what we are seeing you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPX. WHEN DID THIS CONDITION BEGIN?** \_\_\_\_\_

**PAST MEDICAL HISTORY:** List any medical conditions you may have \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY:** List any surgeries you may have had \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### CURRENT MEDICATIONS:

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

Additional Meds: \_\_\_\_\_

**CURRENT ALLERGIES:** Please check all that apply.

Penicillin  Novocaine  Sulfa  Iodine  Aspirin  None

Other-please list: \_\_\_\_\_

### SOCIAL HISTORY:

Tobacco: packs per day \_\_\_\_\_ How many years? \_\_\_\_\_ When did you quit \_\_\_\_\_

Alcohol: how often and how much each week? \_\_\_\_\_

**Job Description:**  Mostly standing  Mostly sitting  Mix of both  Retired

\_\_\_\_\_  
\_\_\_\_\_

I hereby give Drs. Koppel and Sassano permission to examine and treat me.

Patient, Parent or Guardian's Signature \_\_\_\_\_

**REVIEW OF SYSTEMS:** Have you had or are you currently having any of the following?

GENERAL	Current	Past	DIGESTIVE	Current	Past
<b>HEAD. EYES. EARS</b>			Heartburn?		
Frequent Headaches?			Vomiting?		
Dizziness?			Constipation?		
Ringin g in Ears?			Diarrhea?		
Change in Hearing?			Black Stools?		
Sore Throat?			Blood with Stools?		
Trouble Swallowing?			<b>CARDIOVASCULAR</b>		
Blurred/Double Vision?			Chest Pain?		
Poor Vision and/or Wear Glasses?			High Blood Pressure?		
<b>RESPIRATORY</b>			Use Oxygen at Home?		
Frequent Colds?			Pacemaker?		
Difficulty Breathing?			Swelling in Ankles/Legs?		
Cough • Productive?			Other?		
Asthma/Hay Fever?			<b>MUSCLE, BONE, JOINTS</b>		
Emphysema?			Leg Pain - at rest?		
Other?			Leg Pain - walking?		
<b>NEUROLOGICAL</b>			Back Pain?		
Change in Memory?			Joint Aching/Pain?		
Trouble with Balance?			Swelling of Joints?		
Change in Sensation?			Difficulty with Joint Motion?		
Where?			Other?		
Other?			<b>SKIN</b>		
<b>BLADDER / KIDNEY</b>			Rash?		
Frequent Urination?			New Growths/Lumps?		
Burning on Urination?			Color Change in Mole or Wart?		
Blood in Urine?			Skin Cancer?		
Difficulty with Urination?			Other?		
Other?					

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Venous Health History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M F

Doctor Name: \_\_\_\_\_

Directions: Please answer the following questions. Provide your best estimate for dates of occurrence.

## Past Medical History

1. Have you ever had vein stripping surgery? Yes No  
If yes, when and which leg? \_\_\_\_\_
2. Have you ever had vein injections? Yes No  
If yes, when, which leg and where on the leg? \_\_\_\_\_
3. Have you ever had a blood clot? Yes No  
If yes, which leg and when? \_\_\_\_\_
4. Have you ever had phlebitis? Yes No  
If yes, which leg and when? \_\_\_\_\_

## Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs?

Father .....	Yes	No
Mother .....	Yes	No
Brother (s) .....	Yes	No
Sister (s) .....	Yes	No
Other _____	Yes	No

1. Do you experience any of the following?
- |                                    |     |    |
|------------------------------------|-----|----|
| a. Aching/pain in your legs? ..... | Yes | No |
| b. Heaviness? .....                | Yes | No |
| c. Tiredness/fatigue? .....        | Yes | No |
| d. Itching/burning? .....          | Yes | No |
| e. Swollen ankles? .....           | Yes | No |
| f. Leg cramps? .....               | Yes | No |
| g. Restless legs? .....            | Yes | No |
| h. Throbbing? .....                | Yes | No |
| Other? _____                       | Yes | No |
- Do you experience these problems in just one, or both legs? One Both
2. Have your veins gotten worse in recent months? Yes No
3. Do you take any medication for pain (eg, advil, etc.)? Yes No
- If yes, what medication and how often? \_\_\_\_\_
4. Do you elevate your legs to relieve discomfort? Yes No
5. Do you wear support hose prescribed by a doctor? Yes No
- If yes, what type and how long have you worn them? \_\_\_\_\_
- \_\_\_\_\_
6. Do you wear light support hose (eg, sheer energy)? Yes No
7. Do they provide relief? Yes No
8. Do you have any problem walking? Yes No
- If yes, how does it affect you? \_\_\_\_\_
9. Do you stand much at work? Yes No  
at home? Yes No
10. Have you ever had any test (s) done on your veins? Yes No
- If yes, when, what type test and where on the leg? \_\_\_\_\_
- \_\_\_\_\_
11. Were you diagnosed with saphenous vein reflux? Yes No