The Vein Clinic at bmc Total Care™
Bend Memorial Clinic P.C.

Date: _____
Name: _____
Age: _____ Date of Birth: _____ Sex: _____
Height: _____ Weight: _____ Shoe Size: _____
Referred by: _____
Reason for your visit today (brief description of the problem):

_____
_____
_____

PERSONAL MEDICAL HISTORY QUESTIONNAIRE

Are you seeking consultation for: Cosmetic reasons Medical reasons Both

How long have you noticed this problem? _____

Have you ever been treated for this problem? Yes No
If yes, by whom? _____
When? _____
What method? (Check all that apply)

Injection (Sclerotherapy)	____	Electrocautery	____
Laser (what type?)	____	Vein Surgery	____
Phlebectomy	____	Vein Stripping	____

Have you ever been treated for one of the following?

	Left Leg	Right Leg	Hospitalization (yes or no)
Phlebitis (inflammation of a vein)	____	____	_____
Leg Ulcer	____	____	_____
Pulmonary Embolism/Blood Clots	____	____	_____
Leg Fracture	____	____	_____

At what age did your varicosities occur? _____

Are they Pregnancy Related? Yes No
Before pregnancy During pregnancy Which pregnancy? _____
What are the ages of your children? _____
After birth control or estrogen therapy? Yes No
Are they Trauma Related: Yes No
After trauma? _____
Other? _____

Are you currently pregnant, or planning a pregnancy soon? Yes No

Are you developing new veins? Yes No Are your present veins getting bigger? Yes No

Indicate which of the following problems you have experienced:

	Right Leg	Left Leg	How Many Years?	Severity (1=least 10=most)
Thigh pain	____	____	_____	_____
Calf pain	____	____	_____	_____
Foot pain	____	____	_____	_____
Swelling of the legs	____	____	_____	_____
Skin problems	____	____	_____	_____
Venous Stasis Ulcers	____	____	_____	_____

Have you ever needed to take medications (over-the-counter or prescription) to help with your vein symptoms?

Yes No

If yes what type? _____ How often? _____

Does your work require a prolonged standing or sitting position? Yes No

Please list your current medications (over-the-counter and prescription):

_____

_____

_____

Do you have any allergies to medications, food, and/or adhesive tape? If so, what is your reaction?

_____

_____

_____

Do you and/or your *family* have a history of:

	Self	Family (Which member?)
Diabetes	____	_____
Thrombophlebitis	____	_____
Phlebitis (inflammation of a vein)	____	_____
Pulmonary embolus	____	_____
Deep vein thrombosis	____	_____
Bleeding disorders	____	_____
Varicose vein problems	____	_____
Leg Ulcers	____	_____
Other health problems that run in your family	____	_____

	Type	Date	Reason	City
Previous Operations/ Surgeries	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Illnesses/Injuries (include any hospitalizations)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Education _____

Marital Status _____

Work History:

Current Occupation _____

Past Jobs _____

Do you smoke cigarettes? Yes No

If yes, how many packs per day? _____

Please indicate how your varicose vein symptoms significantly impact specific activities of daily living (excluding "at work" symptoms).

Please circle all that apply:

1. Do you have pain when taking a shower or bath? Yes No
2. Do you have any bleeding from the veins? Yes No
3. Does getting dressed hurt? Yes No
4. Does it hurt if you bump them? Yes No
5. Does it hurt to cross your legs? Yes No
6. Do you have pain with meal preparation? Yes No
7. Do you have pain when doing household chores? Yes No
8. Does it hurt to garden or mow the grass? Yes No
9. Do you have pain with exercise? Yes No
10. Do you have pain when grocery shopping? Yes No
11. Do you have pain when you bend or squat? Yes No
12. Does it hurt when you are sleeping? Yes No
13. Does it hurt when your dog or cat jump on your legs? Yes No
14. Does it hurt to sit for an extended period of time? Yes No
15. Does it hurt to stand for an extended period of time? Yes No

Have you been using conservative therapy with the use of medical grade compression stockings (minimum of 20mmHg) for a minimum of 3 months? Yes No

If yes, please indicate the date that you started wearing the compression stockings_____

Please list any other pertinent symptoms of your varicose veins that have an impact on your daily living that have not been listed above:

_____

_____

_____

_____

Patient Signature _____ Date_____

Please **CIRCLE** any of the conditions that you have had in the last **6 MONTHS**.

GENERAL:
Unusual fatigue or weakness
Chills, fever
Unable to sleep
Weight changes
Night sweats
Excessive thirst
Bleeding tendency

HEAD:
Frequent headache
Dizziness
Loss of balance
Fainting spells

EYES:
Wear glasses or contact lenses
Change in vision
Blurry vision
Eye pain
Spots before eyes
Blind areas

EARS:
Hearing loss
Ringing in ears

NOSE:
Bleeding
Congestion
Sinus trouble
Post nasal drip
Discharge

THROAT & MOUTH:
Wear dentures
Sore mouth, tongue, lips
Hoarseness
Frequent sore throat
Bleeding gums

NECK:
Stiffness
Pain
Swelling

HEART:
High or low blood pressure
Irregular or skipped beats
Racing or fluttering
Pounding
Chest pain
Swollen feet, ankles
Murmur

LUNGS:
Persistent cough
Coughing up blood
Difficulty breathing
Wheeze
Sit up to breathe

STOMACH & INTESTINAL:
Appetite poor
Difficulty swallowing
Frequent indigestion or heartburn
Nausea/vomiting
Diarrhea
Black stools
Change in bowel habits
Hemorrhoids
Abdominal pain/stomach ache
Bright blood in stool
Constipation
Laxatives

URINARY:
Pain or burning on urination
Night frequency, excessive
Day frequency, excessive
Slow starting or stopping
Slow urine stream
Lose urine with cough, sneeze
Bloody or dark urine

BONES, JOINTS, MUSCLES:
Painful or stiff joints
Swollen joints
Back pain
Pain or burning legs/feet
Cramps on muscles of legs
Muscle weakness or soreness

SKIN: (where, etc.)
Rash, hives, or itching _____
Bruise easily
Change in mole or wart _____
Sore, not healing well

BREAST:
Lump
Pain
Discharge

MOOD:
Lack of memory
Cry often
Depressed
Irritable
Anxiety
Upset easily
Tense or under stress
Considered suicide

SEXUAL:
Unsatisfactory
Trouble in performance
Painful intercourse
Other

NERVOUS SYSTEM: (where, etc.)
Numbness _____
Tingling _____
Loss of sensation _____
Paralysis _____
Trembling
Seizures

MENSTRUAL:
Age of onset _____
Last period _____
Duration of flow _____
Last PAP smear _____
Result _____
Menstrual pain
Bleeding between periods
Discharge
Excess menstrual bleeding
Birth control _____
Hot flashes
Bleeding after menopause

HABITS:
Coffee
Cigarettes
Alcohol
Exercise

Do you have any concerns not included on this page?
Yes No
(specify) _____
_____