Ozark Regional VEIN CENTER

Patient Name _____

Date of Visit _____ Date of Birth _____

Health History 1 | Health History 2 | Review of Systems

☐ All Negative

	Which Side? Please circle one	if yes, when?
An injury to either of your legs that required an operation or casting?:	R L B Neither	
A deep vein thrombosis (D.V.T.). AKA a blood clot in your leg?	R L B Neither	
Phlebitis:	R L B Neither	
A Venous Stasis Ulcer?	R L B Neither	
Hemorrhage from a Varicose Vein?	R L B Neither	
Sclerotherapy:	R L B Neither	
Vein Stripping:	R L B Neither	

Criteria For Medical Necessity

Patient's Complaint:

Patient Works as ... Retired? ☐

Patient has had to: (None of the Above)

- ☐ wear support hose
- ☐ limit activities
- ☐ take time off work
- ☐ take pain medicine
- ☐ exercise
- ☐ lose weight: ____ lbs
- ☐ elevate legs
- ☐ take oral analgesics

# of Childbirths: ____

Cons Treat Duration: ____ ____

Please indicate if you have any of the following conditions

- ☐ Diabetes
- ☐ Renal Failure
- ☐ Hypertension
- ☐ Fainting
- ☐ Seizures
- ☐ Lung Disease
- ☐ HIV Infection
- ☐ Cancer
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Tobacco Use

Current Medication (Checklist)

- ☐ Coumadin
- ☐ Plavix
- ☐ Daily Aspirin
- ☐ Topical Skin Medications
- ☐ Antibiotics
- ☐ Steroids

For Women Only

- ☐ Pregnant or think you might be?
- ☐ Currently Nursing (Breast Feeding)?
- ☐ Do you think you will have more children?
- ☐ Taking Oral Contraceptives?
- ☐ On Hormone Replacement Therapy (HRT)?
- ☐ Do you anticipate starting HRT Soon?

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Please list all medications that you take at least three times per week:

Allergies

Please list any and all allergies (click text box to edit list):

☐ Patient has allergies important to us.

Family History: Please indicate if any of the following conditions were present in your immediate family members

- ☐ Varicose Veins
- ☐ Venous Ulcers
- ☐ Deep Vein Thrombosis
- ☐ Phlebitis
- ☐ A history of Vein Surgery
- ☐ Blood Clots

Past Surgical History

☐ Have you ever had surgery?

If you have had surgery, what type and when?

Additional Medical History Not Mentioned Above:

☐ Are you presently seeing another physician for anything NOT mentioned above?

If so, What is the Doctors Name?:

Currently Seeing Another MD For What Text:

☐ Have you ever been hospitalized for anything NOT mentioned above?

If so, for what, at what Hospital, and when?

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Do you currently have any of the following? If yes, please explain.

☐ All Negative (Page 3)

☐ General Health/Recent illness

☐ Fever ☐ Chills ☐ Weight loss ☐ Loss of appetite

☐ Eyes

☐ Visual acuity ☐ Double vision ☐ Excessive tearing ☐ Crusting

☐ ENT (Ear, Nose, and Throat)

☐ Recent change in hearing ☐ Discharge ☐ Sore throat ☐ Dizziness ☐ Ringing in the ears

☐ Cardiac (History of heart disease)

☐ Chest pain ☐ Shortness of breath ☐ Waking from sleep breathless ☐ Cardiac medicine

☐ Respiratory

☐ Shortness of breath ☐ Productive cough ☐ Coughing up blood ☐ Painful breathing

☐ Gastrointestinal

☐ Change in bowel movements ☐ Black stool ☐ Red or bloody stool ☐ Vomiting ☐ Abdominal

☐ Genitourinary

☐ Incontinence ☐ Frequent urination ☐ Urgent urination ☐ waking at night to urinate

☐ Musculoskeletal

☐ Change in walking ability or strength ☐ Painful joints

☐ Skin

☐ Problematic rashes or itching ☐ Changes in skin color ☐ Sores that will not heal

☐ Neurological

☐ Unexpected/unexplained numbness ☐ Tingling ☐ Loss of memory ☐ Loss of movement

☐ Psychiatric

☐ Suicidal thoughts or hallucinations