Patient Medical History

Patient Name: _____Date: _____

Please check if you have ever been diagnosed with or treated for the following: ○ None

○ **High Blood Pressure** ○ **Diabetes** ○ Heart Disease ○ Asthma ○ Arthritis

○ Superficial Phlebitis ○ **Pulmonary Embolus** ○ HIV/AIDS ○ Hepatitis ○ Migraines

○ Lung Disease/COPD ○ **Blood Clots (DVT)** ○ Other: _____

Have you ever had surgery? ○ Yes ○ No

If yes, what type of surgery and when? _____

_____

Are you currently taking any medications? ○ Yes ○ No

If yes, please list_____

_____

Are your allergic to any medications / Latex? ○ Yes ○ No

(If yes, please list) _____

Do you take any blood-thinning medication? ○ Yes ○ No

(If yes, please list)_____

Have you ever had a prior leg injury or fracture? ○ Yes ○ No

(If yes, please explain)_____

Is there a family history of:

Blood Clots ○ Yes ○ No

(If yes, please explain)_____

Varicose or Spider Veins: ○ Yes ○ No

(if yes, please explain)_____

Do you smoke? ○ Yes ○ No

If yes, how many packs per day?_____

R.O.S. (Check if Positive): ○ Chest Pain ○ Shortness of Breath ○ Asthma ○ Migraines ○ Abdominal Pain

Females Only:

Are you pregnant or trying to become pregnant? ○ Yes ○ No

Are you currently taking hormones or birth control? ○ Yes ○ No

Are you currently breast-feeding? ○ Yes ○ No

Were your veins made worse with pregnancy? ○ Yes ○ No

Total number of pregnancies you had:_____ How many children?_____ # of miscarriages_____

Patient Signature_____ Date _____