The Vein Institute of Utah

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CONFIDENTIAL MEDICAL HISTORY FORM

IMPORTANT: Please use black ink and fill out completely.

Patient name: ______________________________ Date of birth: ______________

Check reason(s) for visit: ____ Varicose Veins ____ Spider Veins ____ Hemorrhoids

1. When did you notice the above problem(s)? ______________________________

2. Have you seen another physician for this problem? ____ Yes ____ No
   If yes, who? ______________________ When? ______________________
   What treatment/testing was recommended? ______________________________
   Was treatment/testing done? ____ Yes ____ No If yes, explain: ______________________

3. List any significant illnesses for which you are *currently* under a physician's care: *(Past Medical History)*
   ______________________ ______________________
   ______________________ ______________________
   ______________________ ______________________

4. List previous operations including cosmetic surgery: *(Past Surgical History)*
   ______________________ ______________________
   ______________________ ______________________
   ______________________ ______________________

5. Medication allergies? Penicillin ____ Yes ____ No Local Anesthetic: ____ Yes ____ No
   Other(s): ______________________________

6. List any current medications, both prescription and non-prescription, including birth-control pills, aspirin, herbs, etc.

Medication	Dosage	Medication	Dosage

7. Do you drink alcohol? ____ Yes ____ No If so, how much? ______________________
   Do you smoke? ☐ Never smoker ☐ Former smoker
   ☐ Current every day smoker ☐ Current some day smoker If so, how much? ______________

8. Are you pregnant or planning a pregnancy soon? ____ Yes ____ No

9. Do you have a pacemaker? ____ Yes ____ No

10. List any Past Family History: *(Include any history of blood clots or bleeding disorders)* ______________________
    ____
    ____
    ____

Patient name: ______________________________ Date of birth: ______________

Review of Medical History:

Condition	Yes	No	Details
HIV	☐ Yes	☐ No	Details: ________
Hepatitis or other Liver Disease	☐ Yes	☐ No	Details: ________
Bleeding disorder	☐ Yes	☐ No	Details: ________
Benign or malignant tumor	☐ Yes	☐ No	Details: ________
Diabetes	☐ Yes	☐ No	Details: ________
High Blood Pressure	☐ Yes	☐ No	Details: ________
Heart Disease or Stroke	☐ Yes	☐ No	Details: ________
Kidney disease	☐ Yes	☐ No	Details: ________
Asthma	☐ Yes	☐ No	Details: ________
Inflammation of a vein (phlebitis)	☐ Yes	☐ No	Details: ________
Blood clot in the legs	☐ Yes	☐ No	Details: ________
Blood clot in the lungs	☐ Yes	☐ No	Details: ________
Stomach or Intestinal Ulcers	☐ Yes	☐ No	Details: ________
Crohn's Disease	☐ Yes	☐ No	Details: ________
Rectal Bleeding	☐ Yes	☐ No	Details: ________
Black Tarry Stools	☐ Yes	☐ No	Details: ________
Constipation or Diarrhea	☐ Yes	☐ No	Details: ________
Change in Bowel Habits	☐ Yes	☐ No	Details: ________
Family History of Colon Cancer	☐ Yes	☐ No	Details: ________
Family History of Varicose Veins	☐ Yes	☐ No	Details: ________
Neurological Disease or Epilepsy	☐ Yes	☐ No	Details: ________
Depression or Emotional Problems	☐ Yes	☐ No	Details: ________

OTHER: *(Please specify)* ______________________________

____

Tests performed:

Test	Never	Yes	Date	Results
Ultrasound of Veins	☐ Never	☐ Yes	Date: ________	Results: ________
Rectal Exam	☐ Never	☐ Yes	Date: ________	Results: ________
Stool Occult Blood	☐ Never	☐ Yes	Date: ________	Results: ________
Sigmoidoscopy	☐ Never	☐ Yes	Date: ________	Results: ________
Colonoscopy	☐ Never	☐ Yes	Date: ________	Results: ________

Review of Lower Leg Symptoms: ***(Varicose or Spider Veins)***

Symptom	Yes	No
Aching	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Numbness or Tingling	☐ Yes	☐ No
Fullness or Pressure	☐ Yes	☐ No
Swelling	☐ Yes	☐ No
Muscle cramping	☐ Yes	☐ No
Leg Restlessness	☐ Yes	☐ No

Review of Rectum Symptoms: ***(Hemorrhoids)***

Symptom	Yes	No
Burning	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No
Protrusions	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

This information is true and correct to the best of my knowledge.

______________________________ ______________

Patient's Signature Date

Complete medical history has been reviewed by physician at the time of office visit and examination:

Reviewed by:

______________________________ ______________

Ehsan Hadjbian, M.D. Date