DALE DENNING, M.D., FACS
4TH STREET HEALTH PLAZA
1130 W. 4TH STREET, SUITE 2051
LAWRENCE, KS 66044
Phone: (785) 856-8346 (VEIN)
Fax: (785) 841-1604

VENOUS PATIENT HEALTH INFORMATION

Name: _____ Date of Birth: _____ Date: _____

Sex: M F Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____

PAST MEDICAL HISTORY

Have you ever been hospitalized as a patient? Yes No

If yes, please specify when and why: _____

_____

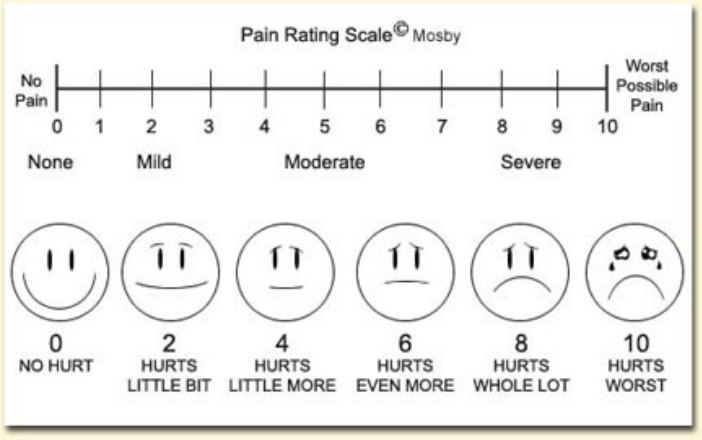
Do you have or have you had any of the following:

Unexpected weight loss	Yes	No	Leg Ulcers/Sores	Yes	No
Heart Disease	Yes	No	Anemia	Yes	No
Heart Murmur	Yes	No	Bleeding disorder	Yes	No
Pacemaker	Yes	No	Thyroid Problems	Yes	No
High Blood Pressure	Yes	No	Cancer	Yes	No
Lung Disease	Yes	No	Seizure	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Hepatitis	Yes	No	Muscle weakness	Yes	No
Stroke	Yes	No	Bone hardware	Yes	No

Do both legs bother you? Yes No

Which leg is the most bothersome to you? Right Left Equal

How would you rate the pain in your legs on a scale of 0-10 _____



Do you take any over-the-counter medications (e.g., aspirin, ibuprofen, NSAIDS or similar type of medication) or prescription medications for aching, cramping, burning or swelling of the lower extremities? If yes, what is the medication and dosage? _____

How many days in a two week period do you take the medication? _____

What other locations do you have pain? _____

Pharmacy Name & Phone Number: _____

Do you have any allergies? Describe how they affect you:

_____ _____

_____ _____

Are you allergic to Latex? Yes No

Please list all current medications - including herbal supplements, vitamins, and over the counter medications, hormones and blood thinners.

Medication	Dosage/Directions	Medication	Dosage/Directions

SOCIAL HISTORY

What is your profession? _____

Do you smoke? Yes No

If yes, how much? _____ If you used to smoke, when did you quit? _____

Do you use alcohol? Yes No If yes, how much per day? _____

Do you use recreational drugs? Yes No If yes, what? _____

Women Only: Childbearing History

Do you think you are presently pregnant? Yes No

How many times have you been pregnant? _____

Do you intend on having more children? Yes No

Are you currently breast-feeding? Yes No

What is the name of your OB/GYN physician? _____

Doctor Initial _____ Date_____

Name: _____ **Date of Birth**: _____ **Date**: _____

Have you ever had surgery of any kind? Yes No (If yes, please specify below)

Previous Surgery	Date	Previous Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

It is important for us to know your family medical history. Please include if any family member has experienced varicose veins, spider veins, leg ulcers, heart failure, or coronary artery disease.

FAMILY	AGE	HEALTH PROBLEMS
Mother (alive/deceased)	_____	_____
Father (alive/deceased)	_____	_____
Sisters (# and ages)	_____	_____
Brothers (# and ages)	_____	_____

Any history of blood clots in your family? Yes No Who? _____

VEIN HISTORY

Do you currently experience any of the following symptoms?

Aching/pain in your legs	Yes	No	Heaviness	Yes	No
Tiredness/fatigue	Yes	No	Itching/Burning	Yes	No
Swollen ankles/legs	Yes	No	Bleeding	Yes	No
Restless legs	Yes	No	Spider Veins	Yes	No
Red/warm areas	Yes	No	Skin Ulcers/sores	Yes	No
Throbbing	Yes	No	Skin Discoloration	Yes	No

Any other symptoms?

_____

How long have you had the symptoms? Months _____ Years _____

Were any of these symptoms related to:

Pregnancy Yes No Accident/Trauma Yes No

Do your symptoms get worse with: Do your symptoms improve with:

Prolonged standing Yes No Walking Yes No

Doctor Initial _____ Date_____

Name: _____ **Date of Birth**: _____ **Date**: _____

Prolonged sitting	Yes	No	Rest/Elevation	Yes	No
Menstrual Cycle	Yes	No	Pain Medication	Yes	No

If yes what do you take? _____

Are you developing new veins? Yes No Where: _____

Are your present veins getting bigger? Yes No Where: _____

Do you stand much at work? Yes No How long? _____

Do you stand much at home? Yes No How long? _____

Have you ever had your veins evaluated before? Yes No

If yes, what doctor and when?_____

Did this doctor perform any tests on your veins (ie: ultrasound)? _____

Do you wear support hose prescribed by a doctor? Yes No

If yes, what brand and do they provide relief? _____ Yes No

How long have you worn support hose? _____

Do you wear light support hose (example: sheer energy)? Yes No

If yes, do they provide relief? Yes No

Have you ever had any vein surgery? (ie: stripping) Yes No

If yes, what leg and what year? Right Left Year _____

Have you ever had any vein injections? Yes No

If yes, what leg and what year? Right Left Year _____

Have you ever had any blood clots? Yes No

If yes, what leg and what year? Right Left Year _____

Have you ever had phlebitis? Yes No

If yes, what leg and what year? Right Left Year _____

Have you ever had a blood transfusion? If yes, what year? Yes No Year _____

PATIENT SIGNATURE: _____ DATE: _____

Doctor Initial _____ Date_____

Name: _____ **Date of Birth**: _____ **Date**: _____