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CONFIDENTIAL PATIENT MEDICAL HISTORY

Patient Name: ______________________ **Date:** ____________ **GP:** ____________________

Do you have a family history of varicose veins or venous ulcers? Which relatives are affected

	LEFT LEG	RIGHT LEG
Do you have spider veins?		
Do you have varicose veins?		
Do you have a leg ulcer?		
How long have you had these vein problems?		
How many times a week to you exercise		
Do you smoke?		

Do you have the following symptoms?

◯ Leg pain or aching ◯ Ankle swelling ◯ Leg cramping ◯ Skin itch ◯ Skin pigmentation

Have you had previous blood clots in your legs? ◯ No ◯ Superficial clot ◯ Deep vein thrombosis (DVT)

Do you suffer from a blood clotting disorder eg. Factor V leiden, Protein S, Protein C ◯ No ◯ Yes

Have you used Warfarin, Clexane or Xeralto (prescription blood thinners) in the past? ◯ No ◯ Yes

Do you suffer from any other medical conditions e.g. Diabetes, asthma, high blood pressure, heart disease, hiv etc.

Do you have an allergy to any medication, please list and rate it – mild, moderate or severe?

Have you had any previous surgeries or procedures for your veins? Please list the surgery and the year.

Do you take any medication every day? Please list