

Patient Name: _____

D.O.B: _____

Please **check** if you have even been diagnosed with or treated for the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Phlebitis/Blood Clots |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease/COPD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | |

Have you ever been tested for or found positive for a Patent Foramen Ovale or Atrial Septal Defect?

- Yes No

Please **check** if you have recently experienced any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Hemoptysis (coughing up blood) |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Palpitations |

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 all prescribed and over-the-counter, vitamins and herbals: _____

Are you allergic to any medications/foods? Yes No

If yes, please list: _____

Do you take any blood-thinning medication (e.g. Coumadin, Plavix or Aspirin)? Yes No

If yes, please list _____

Do you smoke? Yes Yes-but not anymore (stopped _____yrs ago) No/Never

If yes, how many packs per day? _____

Do you consume alcohol? Yes Yes-infrequently No/Never

Is there a family history of blood clots? Yes No

If yes, please explain: _____

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

If yes, please explain: _____

Do you take antibiotics before dental or Invasive procedures? Yes No

Family History of Varicose or Spider Veins (please check):

- No family history of vein disease
- Mother Father Sister Brother
- Grandmother Grandfather Uncle Aunt

Females Only:

Are you pregnant or trying to become pregnant? Yes No

Are you currently breast-feeding? Yes No

Are you taking hormones or birth control pills (ex: Estrogen, Progesterone or Tamoxifen)? Yes No

If yes, please list: _____

For how many years: _____

Total number of pregnancies you have had: _____

Were your veins made worse with pregnancy? Yes No

Physician Signature: _____

Date: _____