Laser Vein Institute
a Division of Diagnostic Imaging Services

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Venous Medical History

Name _____ Date _____

Primary Physician _____ Date of Birth _____

Please list any allergies you have: _____

Reason you are seeking treatment for your veins:

Medical reasons _____

Cosmetic reasons _____

How long have you had the veins you are concerned about? _____

Did your veins develop during a pregnancy? _____

Does prolonged sitting or standing aggravate your veins? Yes No

Are your veins getting worse? _____

Have you ever had treatment for your veins? If yes, where and what type of treatment? _____

_____

Do your legs ever (please circle if appropriate): Swell Ache Become red & inflamed

Have you ever been treated for a blood clot in your legs, if yes when and which leg? _____

_____

Do you or have you ever worn compression hose, and if yes for how long and did it help your veins? _____

_____

Please list any medications you are currently taking: _____

_____

_____

Please circle any of the following medical problems you have:

High Blood Pressure	Cancer	Heart Disease
Lung Disease/Asthma	Diabetes	Liver Disease

Please list any pertinent medical condition you have, that we have not listed: _____

_____

_____

Please list previous surgeries and dates: _____

_____

_____