Texas Vein and Cosmetic Specialists

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CONSULTATION **DATE:**

_____

PATIENT NAME **DATE OF BIRTH** **AGE** **MALE / FEMALE**

REASON FOR CONSULTATION:

THE PATIENT IS HERE FOR EVALUATION OF _____.

HT: _____ WT: _____ BP: _____/_____ PULSE: _____ RESP: _____

HISTORY OF PRESENT ILLNESS:

Number of years veins have been a concern _____
Vein problem noted during pregnancy. Yes No
Veins aggravated by prolonged standing: Yes No
Veins have increased in severity: Yes No
Previous vein treatment: Yes No
Type of Vein Treatment:_____
Symptoms: Swelling _____ Aching _____ Inflammation _____
Previous treatment for blood clots: Yes No Location of blood clots: _____
Compression support hose used: Yes No How long: _____

Family history of vein disease: Yes No
Family Member: _____
Smoke: Yes No # of years: _____
Exercise: Yes No How often: _____

PAST MEDICAL HISTORY:

Heart Attack _____	**High Cholesterol _____**	**Renal Insufficiency _____**
Chest Pain _____	**Hypertension _____**	**Lupus/Scleroderma _____**
Stroke _____	**Bleeding or Clotting Disorders _____**	**Emphysema _____**
Diabetes _____	**Pulmonary Embolism _____**	**Liver Disease _____**

Other Illnesses: _____

DRUG ALLERGIES: _____

MEDICATIONS: **(List Additional Medications on the back of this form)**

Name	Strength	Directions

PAST SURGERIES: (List Additional Surgeries on the back of this form)

_____ _____

_____ _____

Medical Assistant reviewing Patient's Medical History: _____