ADVANCED
VEIN CARE SOLUTIONS

PATIENT HISTORY AND MEDICATION FORM

NAME:_____ **Date:** _____

Family History	**Relationship**
_____ Clotting Disorder	_____
_____ Bleeding Disorder	_____
_____ Coronary Artery Disease	_____
_____ Varicose Veins	_____
_____ Stroke	_____
_____ Aneurysm	_____

_____ Tanning?
(Tanning not allowed 1 month before or after a procedure)

_____ Currently breastfeeding a child?
(Breastfeeding must be completed entirely before procedures can be performed.)

Patients Past Medical History

(Place "X" where applicable)

_____ Hypertension
_____ Hyperlipidemia
_____ Hypercholesterolemia
_____ Coronary Artery Disease
_____ Aneurysm
_____ Cerebral Embolism
_____ Renal Insufficiency Syndrome
_____ Peripheral Vascular Disease
_____ Peripheral Neuropathy
_____ Diabetes Mellitus
_____ Deep Vein Thrombosis
_____ Thrombophlebitis
Other _____

Patients Surgical History		**Year**
Past Varicose Vein Ligation w/Stripping	YES or NO	

Social

_____ Tobacco Use
Packs per day _____
_____ Alcohol Use
Frequency _____

Living Situation

(Please circle one)

With Spouse With Family

Alone Nursing Home

Current Medications

	Name	**Dosage**	**Frequency**
Blood Thinners	Yes or No		
Birth Control	Yes or No		

Alergies to Medications