LEGACY HEALTH & WELLNESS
VEIN.HORMONE.IV.SPECIALISTS.

Today's Date: _____ **MEDICAL HISTORY FORM** **Date of Birth:** _____

Last Name: _____ **First Name:** _____ **MI:** _____

Allergies: ☐ none ☐ yes, please list: _____ **Height:** _____ **Weight:** _____
(food, medications, latex, or other substances)

What are you here for today? ☐ Varicose veins ☐ Hormone therapy ☐ IV therapy ☐ Procedure: (please list)
☐ Spider veins _____

Please answer all of the following questions:

Review of Systems: Do you currently have **ANY** of the following symptoms? (Please circle below)

Fever	yes	no	Chest pain	yes	no	Pain with urination	yes	no
Chills	yes	no	Palpitations	yes	no	Incontinence	yes	no
Night sweats	yes	no	Leg swelling	yes	no	Rash	yes	no
Fatigue	yes	no	Leg pain	yes	no	Ulcers	yes	no
Weight loss	yes	no	Pain with walking	yes	no	Weakness	yes	no
Weight gain	yes	no	Discoloration of skin	yes	no	Back pain	yes	no
Headaches	yes	no	Varicose veins	yes	no	Leg pain	yes	no
Sore throat	yes	no	Spider veins	yes	no	Numbness	yes	no
Vision changes	yes	no	Leg cramps	yes	no	Tingling	yes	no
Hearing loss	yes	no	Nausea	yes	no	Dizziness	yes	no
Shortness of breath	yes	no	Vomiting	yes	no	Memory loss	yes	no
On home oxygen	yes	no	Constipation	yes	no	Bruising	yes	no
Cough	yes	no	Diarrhea	yes	no	Easily bruises	yes	no
Coughing up blood	yes	no	Changes in bowel	yes	no	Itching	yes	no
Wheezing	yes	no	Changes in bladder	yes	no	Other _____		
Snoring	yes	no	Blood in urine	yes	no	_____		

1. Are you pregnant or could you be? ☐ n/a ☐ no ☐ yes, are you breastfeeding? ☐ yes ☐ no
2. Are you currently under a doctor/NP/PA care? ☐ no ☐ yes, for what reason: _____

Past Medical History: Do you have **ANY** current or chronic medical illnesses? (Please circle below)

Diabetes	yes	no	COPD/Asthma	yes	no	Blood Clots	yes	no
High blood pressure	yes	no	Emphysema	yes	no	Thyroid Disease	yes	no
Heart attack	yes	no	Hepatitis	yes	no	Bleeding Disorder	yes	no
Heart disease	yes	no	HIV	yes	no	Anesthesia problems	yes	no
Heart failure	yes	no	Arthritis	yes	no	Pacemaker	yes	no
Atrial Fib	yes	no	Lupus	yes	no	Immunosuppression	yes	no
High Cholesterol	yes	no	Gastric Reflux	yes	no	Photosensitive Disorders	yes	no
Stroke/mini stroke	yes	no	Kidney Disease	yes	no	Heat Urticaria	yes	no
Seizures	yes	no	Depression	yes	no	Cancer _____	yes	no
Gastric Ulcers	yes	no	Fibromyalgia	yes	no	Other: _____		

Past Surgical History: Have you underwent **ANY** surgical procedures: ☐ no ☐ yes, please list what surgery and when:

1. _____ 2. _____
3. _____ 4. _____

Family History: Does your family have any history of the following:

☐ Heart Disease ☐ Kidney Disease ☐ Blood Clots ☐ Aneurysm ☐ Cancer ☐ Diabetes
☐ Hypertension ☐ Varicose Veins ☐ Bleeding Disorder ☐ High Cholesterol ☐ Stroke/Mini stroke ☐ Other: _____

Social History: Do you smoke? ☐ no ☐ yes, when did you quit? _____ # Packs per day? _____ # Years? _____
Do you drink alcohol? ☐ no ☐ yes, how often? _____ Do you use nonprescription drugs? ☐ no ☐ yes

Medications: Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ none ☐ yes, please list all medications below or provide a list:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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VEIN Consultations Questions	**YES**	**NO**
1. Do you experience any pain your legs?	☐	☐
If so, please describe: ☐ aching ☐ throbbing ☐ cramping ☐ heaviness ☐ sharp ☐ shooting ☐ restless ☐ other: _____		
2. Do you have any leg swelling?	☐	☐
3. Do you have any skin discoloration?	☐	☐
4. Do you have any current of history of any problems with ulcers?	☐	☐
5. Do you have any of the known following conditions: (Please check below)	☐	☐
☐ Varicose Veins ☐ Spider Veins ☐ Phlebitis ☐ Cellulitis ☐ Chronic venous insufficiency		
6. Have you had any procedures performed on your veins? (Please check below)	☐	☐
☐ EVLT ☐ RFA ☐ Phlebectomy ☐ Vein stripping ☐ Sclerotherapy ☐ Laser spider veins		
7. Do you or have you ever worn compression hose?	☐	☐
8. Have you tried to elevating the legs your legs?	☐	☐
9. Have you tried anti-inflammatory or pain medication?	☐	☐
10. Are you taking any blood thinners?	☐	☐
Please list: _____		

HORMONE Consultations Questions	**YES**	**NO**
1. Do you have any problems sleeping? (difficulty falling asleep, sleeping through the night, waking early)	☐	☐
2. Do you have any problems with depression? (feeling down, sad, on verge of tears, lack of drive, mood swings)	☐	☐
3. Do you have any trouble with feeling irritable? (feeling nervous, inner tension, aggressive)	☐	☐
4. Do you have any problems with anxiety? (restlessness, feeling panicky)	☐	☐
5. Do you have any hot flashes or night sweats? (episodes of sweating, flushing face & neck)	☐	☐
6. Do you have any palpitations? (heart skipping, racing, tightness)	☐	☐
7. Do you have any problems with hair loss?	☐	☐
8. Do you have any problems with your energy level? (general decrease in performance)	☐	☐
9. Do you have any problems with focusing? (impaired memory, decreased in concentration, forgetfulness)	☐	☐
10. Do you have any problems with sexual function? (desire, activity, satisfaction)	☐	☐
11. Do you have any problems with body-joint pains? (joints, muscular discomfort, rheumatoid)	☐	☐
12. Do you have any problems with exercise tolerance? (extreme tiredness during/post workout)	☐	☐
13. [For Women] Do you experience vaginal dryness? (sensation of dryness or burning, difficulty with sexual intercourse)	☐	☐
14. [For Women] Are menstrual periods regular?	☐	☐

Patient Signature: _____ Date: _____