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Specialist Vein Care

Medical History Questionnaire

Please take a few minutes to answer the following questions carefully as this assists us in preparing for your assessment. The information from this Questionnaire may be used for research purposes. Your personal details will be withheld. Please tick what is correct.
If you are not sure about the answer, leave it blank and ask the Doctor at your consultation.

Surname: .....

First Name: .....

Date of birth: .....

Phone No: (H) ..... (Mob) .....

Medicare Card No: .....

Pension Card No: .....

Address: .....

.....

Name & Address of your Family Doctor: .....

.....

.....

How did you find out about us?

- ☐ Friend
- ☐ Magazine
- ☐ Doctor Referral
- ☐ Word of Mouth

Your Current Complaint

1. Are you consulting for:

- ☐ a. Varicose veins of the legs
- ☐ b. Spider veins of the leg
- ☐ c. Leg ulcers
- ☐ d. Recurrence of the veins after an operation
- ☐ e. Recurrence of the veins after injection
- ☐ f. Recurrence of the veins after Laser
- ☐ g. Pelvic congestion
- ☐ h. Varicose veins of the vagina
- ☐ i. Lymphatic problem of the legs
- ☐ j. Check-up
- ☐ k. Other *(please specify)* ----------

Your Symptoms

2. Indicate which of the following problems you have experienced:

- ☐ a. Pain in your legs
- ☐ b. Heaviness in the legs
- ☐ c. Bursting pain in the calf after exercise
- ☐ d. Burning sensation in the calf
- ☐ e. Night cramps in the legs
- ☐ f. Itchiness in the legs
- ☐ g. Leg rash
- ☐ h. Swelling in the legs
- ☐ i. Tiredness in the legs
- ☐ j. Restlessness in the legs
- ☐ k. Other *(please specify)* ----------

3. If you experience pain in your legs:

a. Does your pain get worse:

Yes	*No*	
☐	☐	a. before your menstrual periods
☐	☐	b. after extended periods of standing
☐	☐	c. with heat
☐	☐	d. at the end of the day
☐	☐	e. following exercise and walking
☐	☐	f. early mornings

Other *(please specify)*: ----------

b. Does the pain get better by:

Yes	*No*	
☐	☐	a. rest
☐	☐	b. elevating the legs
☐	☐	c. elastic stockings
☐	☐	d. medication: ----------
☐	☐	e. exercise and walking
☐	☐	f. when you stand up

Other *(please specify)*: ----------

Onset of Veins

4. When did your veins occur?

- ☐ a. Age: ----------
- ☐ b. Since childhood
- ☐ c. After an operation
- ☐ d. After Trauma
- ☐ e. After taking the contraceptive pill
- ☐ f. Before pregnancy
- ☐ g. During pregnancy
- ☐ h. After pregnancy (while breast feeding). Specify which pregnancy: ----------
- ☐ i. After menopause ----------

Other *(please specify)*: ----------

5. Ladies only. Do you suffer from:

- ☐ a. Heaviness in the lower abdomen
- ☐ b. Pain in the lower abdomen
- ☐ c. Burning sensation in the groin
- ☐ d. Difficult and painful intercourse
- ☐ e. Haemorrhoids
- ☐ f. Frequent urination
- ☐ g. Constipation

Past Venous History

6. Have you had any of the following:

Yes	*No*	
☐	☐	a. Phlebitis (inflammation of a vein)
☐	☐	b. DVT (blood clot in a deep vein)
☐	☐	c. Pulmonary embolism (blood clot in lung)
☐	☐	d Ulcer of the legs
☐	☐	e. Bleeding disorder
☐	☐	f. Easy bruising
☐	☐	g. Required Warfarin or had injections in the tummy for any reason

7. Have you had previous treatments for your veins?

Yes	*No*
☐	☐

If yes, with what method?

☐	☐	a. Injection
☐	☐	b. Operation
☐	☐	c. Laser
☐	☐	d. Other *(please specify)*:

By whom and when?.....

.....

Did you have any problems afterwards? .....

Were you happy with the overall results?.....

Past Medical History

8. Do you have a history of:

Yes	*No*	
☐	☐	a. HIV / AIDS
☐	☐	b. Hepatitis – A, B, or C, please indicate
☐	☐	c. Blood transfusions
☐	☐	d. Asthma
☐	☐	e. Diabetes – on Insulin, tablets, or diet controlled?
☐	☐	f. High blood pressure
☐	☐	g. Seizures, convulsions or epilepsy
☐	☐	h. Stroke
☐	☐	i. Bad circulation
☐	☐	j. Cancer
☐	☐	k. Arthritis or other types of auto-immune disease (e.g. Lupus)
☐	☐	l. Thyroid problems *(please specify)*----------
☐	☐	m. Heart disease
☐	☐	n. Migraine
☐	☐	Other medical problems *(please specify)* ----------

Gynaecological History *(Ladies only)*

9. How many times have you been pregnant? (include any termination or miscarriage)

.....

10. How many children do you have? .....

Yes	*No*	
☐	☐	**11. Are you pregnant? (if applicable)**
☐	☐	**12. Are you planning a pregnancy soon? (if applicable)**
☐	☐	**13. Are you currently breast feeding? (if applicable)**
☐	☐	**14. Have you had a hysterectomy? (if applicable)**
		If yes, what year? .....
☐	☐	**15. Are you taking the Pill? (if applicable)**
		If yes, which one? .....
		For how long? .....
☐	☐	**16. Hormone Replacement Therapy? (if applicable)**
		If yes, which one? .....
		For how long? .....

Surgical History

17. Please name all operations you have had with relevant year

.....

.....

Family History

18. Do you have a family history of:

Yes	*No*	
☐	☐	a. Varicose vein problems
☐	☐	b. Spider veins
☐	☐	c. Phlebitis (Inflammation of the vein)
☐	☐	d. Blood clots
☐	☐	e. Bleeding disorders
☐	☐	f. Leg ulcers
☐	☐	g. Other problems affecting the veins or circulation? *(please specify)*

Psychological History

19. Do you suffer from:

Yes	*No*	
☐	☐	a. Anxiety
☐	☐	b. Panic attacks
☐	☐	c. Claustrophobia
☐	☐	d. Needle phobia
☐	☐	e. Other psychological or psychiatric disorder *(please specify)*:

Social History

20. About you:

- ☐ a. single
- ☐ b. married
- ☐ c. smoker ..... / day
- ☐ d. regular alcohol ..... /day
- ☐ e. social drinker
- ☐ f. occupation .....

Medications

21. Regular Medications:

.....

.....

21. Are you taking Iron Tablets?

Yes ☐ *No* ☐

If yes for how long? .....

For what reason? .....

23. Do you take aspirin or anti-inflammatory drugs? *(e.g. Voltaren, Naprosyn, etc)*

Yes ☐ *No* ☐

Allergies

24. Have you had any of the following allergic reactions?

Yes *No*

☐ ☐ a. Eczema

☐ ☐ b. Hives

☐ ☐ c. Hay fever

☐ ☐ d. Anaphylactic shock (severe life threatening allergic reaction)

If yes, please explain what happened:

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25. Do you have an allergy to any of the following?

If you answer "Yes" to any of the following, please explain what happens if you take them.

Yes *No*

☐ ☐ a. Foods ----------

☐ ☐ b. Local anaesthetic ----------

☐ ☐ c. Tapes ----------

☐ ☐ Other ----------

26. What are your feelings towards surgery on your veins?

☐ a. Don't mind

☐ b. If really necessary

☐ c. Opposed

27. Are there any pending travel arrangements?

Yes *No*

☐ ☐

If yes please give details) ----------

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28. Have you had any problems with your legs with travel?

Yes *No*

☐ ☐

If yes please give details) ----------

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