WATERFORD
VEIN INSTITUTE

R. Randolph Waterford, MD, FACS, RVT, RPVI

# Patient Medical History

Patient Name: _____Date:_____ D.O.B:_____

**What is the reason for your visit?:**_____

**Please check if you have even been diagnosed with or treated for the following:**

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Arthritis
- ☐ Pulmonary Embolus
- ☐ Heart Disease
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Cancer_____
- ☐ Hepatitis
- ☐ Phlebitis/Blood Clots- Superficial or Deep
- ☐ Lung Disease/COPD
- ☐ Other _____

**Please check if you have recently experienced any of the following:**

☐ Night Sweats ☐ Unexplained Weight Loss ☐ Persistent Cough ☐ Loss of appetite ☐ Fever ☐ Hemoptysis (coughing up blood)

**Are you ALLERGIC to any of the following**? ☐ Food ☐ Medicine ☐ Latex Products ☐ Seafood/Shellfish ☐ Iodine/Contrast Dye

If yes, please list, along with type of reaction_____

**Have you ever had an ALLERGIC reaction during a medical procedure**? ☐ Yes ☐ No

If yes, please list, along with type of reaction_____

**Have you ever had surgery?** ☐ Yes ☐ No

If yes, what type of surgery and when? _____

**Are you currently taking any medications?** ☐ Yes ☐ No

If yes, please list (name and dosage) _____

_____

**Do you smoke?** ☐ Yes ☐ No

If yes, how many packs per day and for how long? _____ If no, did you ever smoke? _____ When did you quit? _____

**Do you drink alcohol?** ☐ Yes ☐ No

If yes, how much and how often? _____

**Is there a family history of blood clots, stroke or heart disease?** ☐ Yes ☐ No

If yes, please explain _____

**Have you ever had a prior leg injury or fracture?** ☐ Yes ☐ No

If yes, please explain _____

**Do you take antibiotics before dental or invasive procedures?** ☐ Yes ☐ No

**Females Only**:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you currently breast-feeding? ☐ Yes ☐ No

Are you taking hormones or birth control pills? ☐ Yes ☐ No If yes, for how many years? _____

Patient Signature _____Date _____

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