



VEIN CENTER
AT IOWA HEART

Medical History Information

Name: _____ Date of Birth: _____ IHC#: _____

Please list all allergies:

Please list all medications (prescription and non-prescription)

Medication	Dosage	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take blood thinning medications?

Yes No If yes, list reason _____

Do you take birth control pills or hormones?

Yes No If yes, list _____

Vein History

Which leg is the most bothersome for you? Right Left Equal

Have you ever had your veins evaluated before? Yes No

If so, what doctor and when? _____

Do you wear support hose prescribed by a doctor? Yes No

If yes, what strength and do they provide relief? Yes No

Have you had any vein surgery? (stripping, laser, or phlebectomy)

Yes No

If yes, what leg and when? Right Left _____

Have you ever had any vein injections? Yes No

If yes, what leg and when? Right Left _____

Have you ever had any blood clots? (DVT- Deep vein thrombosis)

Yes No

If yes, what leg and when? Right Left _____

Were you put on any blood thinning medications? Yes No

If so, what medications? _____

Have you ever had superficial thrombophlebitis? (Superficial blood clots)

Yes No

If yes, what leg and when? _____

Have you ever had a pulmonary embolism (PE)? (Blood clot to the lung)

Yes No

If yes, when? _____

Past and Current Medical History

Have you ever had any surgery of any kind?

Yes No

If yes, when and what type of surgery? _____

Do you have?

	Yes	No		Yes	No
Heart Disease			Pacemaker/ Defibrillator		
Lung Disease			Hepatitis		
Peripheral Vascular Disease			Arthritis		
Leg Ulcer			Diabetes		
Asthma			Thyroid Disease		
High Blood Pressure			Anemia		

	Yes	No
Do you think you are presently pregnant?		
How many times have you been pregnant?		
Are you currently breastfeeding?		

Do you have a history of?

	Yes	No
Tuberculosis (TB)		
HIV		
Hepatitis A, B, or C		
Methicillin-Resistant Staphylococcus Aureus (MRSA)		