south coast VEIN INSTITUTE

South Coast Vein Institute
Warrnambool Suite 13, 136 Botanic Rd, Warrnambool, Victoria 3280
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Phone (03) 5562 5330 **Fax** (03) 5562 5360 **Email** info@scvi.net.au
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Medical History Questionnaire

1. What is your current complaint?
   - ☐ Varicose veins of the legs
   - ☐ Spider veins of the legs
   - ☐ Recurrence of veins after previous treatment (Laser / Injections / Surgery)
   - ☐ Other: ……

2. Which symptoms have you experienced?
   - ☐ Pain in the legs
   - ☐ Heaviness of the legs
   - ☐ Burning sensation of the calves
   - ☐ Night cramps in the legs
   - ☐ Swelling of the legs
   - ☐ Restlessness of the legs
   - ☐ Itchiness of the legs
   - ☐ Leg rash
   - ☐ Other: ……

3. If you experience pain in your legs:
   a. Does your pain get worse?
      - ☐ With prolonged standing
      - ☐ With heat
      - ☐ Following exercise
      - ☐ At the end of the day
      - ☐ If female – before your menstrual period
      - ☐ Other: ……

   b. Does the pain get better with?
      - ☐ Rest
      - ☐ Leg elevation
      - ☐ Compression stockings
      - ☐ Medication – which one:……..
      - ☐ Exercise
      - ☐ Other: ……

4. When did your vein problems begin?

   Age: ……..

   If female:
   - ☐ After taking the Oral Contraceptive Pill
   - ☐ Before pregnancy

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- ☐ During pregnancy
- ☐ After pregnancy
- ☐ After menopause
- ☐ After an operation
- ☐ After trauma
- ☐ Other: ……

5. Do you have a past history of:
   - ☐ Phlebitis - vein inflammation
   - ☐ Deep Vein Thrombosis (DVT) – clot in a vein
   - ☐ Pulmonary Embolism – clot in the lung
   - ☐ Leg ulcers
   - ☐ Bleeding disorder
   - ☐ Easy bruising/bleeding
   - ☐ Required blood thinners for any reason (Warfarin/Clexane/other)
   - ☐ Other: ……

Have you had previous treatments for your veins?

- ☐ Yes
- ☐ No

If yes, what treatments have you had?

- ☐ Injections
- ☐ Surgery
- ☐ Laser
- ☐ Other: ……

When: ……

Name of treating doctor: ……

Did you have any complications? ……

Were you happy with the results? ……

6. Do you have a medical history of:
   - ☐ Asthma
   - ☐ Eczema
   - ☐ Hayfever
   - ☐ Anaphylactic shock (severe life threatening allergic reaction)
   - ☐ Diabetes
   - ☐ Gastric reflux/heartburn/stomach ulcers
   - ☐ High blood pressure
   - ☐ Seizures / Epilepsy
   - ☐ Stroke
   - ☐ Cancer

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- ☐ Autoimmune disease (e.g. Lupus, Rheumatoid Arthritis)
- ☐ Thyroid issues
- ☐ Heart disease
- ☐ Migraine
- ☐ Hole in the heart
- ☐ HIV/AIDS
- ☐ Hepatitis (A/B/C)
- ☐ Blood transfusion
- ☐ Other: ……

7. If female – **Gynaecological** History
   - ☐ How many times have you been pregnant? (please include terminations and miscarriages) ……
   - ☐ How many children do you have?……
   - ☐ Are you pregnant?
   - ☐ Are you planning a pregnancy soon?
   - ☐ Are you currently breastfeeding?
   - ☐ Have you had a hysterectomy?
     Year:……..
   - ☐ Are you taking the Oral Contraceptive Pill?
     Brand:……..
     Year started:……..
   - ☐ Are you on Hormone Replacement Therapy?
     Brand:……..
     Year started:……..

8. Have you had any surgeries? Please list operation name and year:
   ……
   ……
   ……

9. Do you have a **family** history of:
   - ☐ Varicose veins
   - ☐ Spider veins
   - ☐ Blood clots
   - ☐ Bleeding disorders
   - ☐ Leg ulcers
   - ☐ Other: ……

10. Do you have a history of?
    - ☐ Anxiety
    - ☐ Panic attacks
    - ☐ Claustrophobia

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- ☐ Needle Phobia
- ☐ Other psychological or psychiatric issues:
  ……

11. Social history
    - ☐ Marital status ……
    - ☐ Do you smoke?
      If yes:
      - ☐ How many per day?……
      - ☐ Year started……..
    - ☐ Do you drink alcohol?
      If yes:
      - ☐ How many per day?……
    - ☐ Occupation ……

12. Please list all your regular medications/vitamins/puffers
    ……
    ……
    ……
    ……

    - ☐ Are you taking iron tablets?
    - ☐ Are you taking fish oil?
    - ☐ Do you take aspirin or anti-inflammatory medications (Nurofen/Voltaren etc.)
    - ☐ Do you take blood thinners (Anticoagulation)

13. Do you have any allergies to medications?
    If yes, please list
    ……
    ……

    - ☐ Are you allergic to tapes?
    - ☐ Are you allergic to latex

14. Do you have any upcoming travel plans?
    If yes, where and when
    ……
    ……

Thank you for filling out this questionnaire