ST. Anthony's

Dr. Brian Peterson, Dr. Gary Peterson
& Dr. Matthew Abate

Venous History Form

Patient Information

Patient Name (First, MI, Last): ____

Birthdate (MM/DD/YY): ____

Primary Care Physician (PCP): ____

Referring Physician (This may be the same as your PCP): ____

What brings you to the clinic today? ____

____

How long have you had this problem? ____

____

Medications (List prescription meds & over-the-counter meds. Type 'None' if you do not take any medications):

____

____

Allergies (List reaction if known. Type 'None' if you do not have any drug/food allergies):

____

____

HAVE YOU HAD ANY OF THE FOLLOWING? (R= right L= left B= both)

☐ Broken bone in the leg R L B
☐ DVT/Blood Clot in the leg R L B
☐ Ulcer/Open Sore on the leg R L B
☐ Aching/Tiredness in the legs R L B
☐ Varicose Veins R L B
☐ Pain in the legs R L B
☐ Swelling in the legs R L B
☐ Skin color changes R L B
☐ Spider Veins R L B
☐ Previous Pregnancies

HAVE YOU BEEN TREATED WITH ANY OF THE FOLLOWING?

☐ Support Hose? If yes; Type/Strength/How Long? ____

☐ Injections/Sclerotherapy?

☐ Vein Stripping or Previous Vein Surgery? Date: _____________

☐ Have you had a Venous Duplex Scan (Ultrasound) of the legs? If so, where? _____________________

PAST MEDICAL AND SURGICAL HISTORY

Past Medical History:

____

____

Surgeries /Hospitalizations (List operations and approximate dates):

____

____

SOCIAL/PERSONAL HISTORY

Employment: ☐Employed ☐Retired ☐Disabled ☐Unemployed

Employment Details (Current Job/ Type of Work): ______________________________

Tobacco Use: ☐Yes/Current ☐Former ☐No/Never

Tobacco Details (Type/Frequency/Quite Date): ______________________________

Alcohol Use: ☐Yes/Current ☐Former ☐No/Never

Alcohol Details (Type/Frequency/Quite Date): ______________________________

Illegal Drug Use: ☐Yes/Current ☐Former ☐No/Never

Illegal Drug Details (Type/Frequency/Quite Date): ______________________________

FAMILY HISTORY (Please list medical problems and cause of death if applicable):

Father: ______________________________ Mother: ______________________________

Siblings: ______________________________ Grandparents: ______________________________

REVIEW OF SYSTEMS (ROS) (Please check all that apply):

Constitutional

☐ Fatigue ☐ Fever ☐ Recent Weight Change

Gastrointestinal

☐ Nausea/Vomiting ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea

Eyes

☐ Eye Disease ☐ Wear Glasses/Contacts ☐ Blurry/Double Vision

Ears/Nose/Throat

☐ Hearing Loss ☐ Change in Voice ☐ Ringing in Ears

Genitourinary

☐ Frequent Urination ☐ Blood in Urine ☐ Impotence

Cardiovascular

☐ Palpitations ☐ Chest Pain/Tightness ☐ Syncope/Fainting

Respiratory

☐ Chronic Cough ☐ Shortness of Breath ☐ Wheezing

Neurological

☐ Seizures ☐ Paralysis ☐ Numbness/Tingling ☐ Headaches

Musculoskeletal

☐ Arthritis ☐ Back Pain

Vascular

☐ Leg Pain with Walking ☐ Pain in Toes at Rest

Skin

☐ Rashes ☐ Lesions/Wounds

Psychiatric

☐ Memory Loss ☐ Depression/Anxiety

Thank you for taking the time to fill out this form. If you have any questions prior to your appointment, please call our office at (314) 525-4325.

Regards,

St. Anthony's Vascular Surgery Office