St. Anthony's

Dr.'s Brian & Gary Peterson

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