Name:_____

Date:_____

DOB:_____ SS #_____

Address:_____ How did you hear about us?_____

City:_____ Maital Status: S M D W

State:_____ Zip Code:_____ Sex: M F Age:_____

Phone # Priority_____ Okay to leave message: Yes or No

Phone# Secondary _____ Okay to leave message: Yes or No

Emergency Contact:_____ Relation to Patient:_____

Phone#_____ Okay to leave message: Yes or No

E-Mail: _____ Access your Electronic Records: Yes or No

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

Primary Insurance:_____

Secondary Insurance:_____

Occupation:_____

Employer:_____ Business Phone: _____

Dr. White's Vein Center, PLLC
1311 Pineview Drive Suite 200
Morgantown, WV 26505

Dr. White's Vein Center

Health History and Questionnaire

Date: _____

Chief complaint: _____ Length of time? _____

Compression stockings/socks? _____ Length of time? _____

Allergies: (medications, environmental)

_____

Medical & Surgical History

_____

Pharmacy/ Medications

_____

Father	Mother	Brother	Sister
Hypertension	Hypertension	Hypertension	Hypertension
Heart Disease	Heart Disease	Heart Disease	Heart Disease
Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes
Varicose Veins	Varicose Veins	Varicose Veins	Varicose Veins
Stroke	Stroke	Stroke	Stroke
Lung Disease	Lung Disease	Lung Disease	Lung Disease
Migraine	Migraines	Migraines	Migraines
Kidney Disease	Kidney Disease	Kidney Disease	Kidney Disease

Social History:

Smoke _____ Alcohol _____ Drink Caffeine _____ Wear seatbelt _____

Having a living will _____ Medical Power of Attorney _____ Exercise _____

Preventative Health:

Mammogram year _____ Colonoscopy year_____

Influenza Vac. year _____ Pneumonia Vac. year _____

Dr. White's Vein Center

Venous Health History Form

Name _____ DOB _____

PCP Name _____

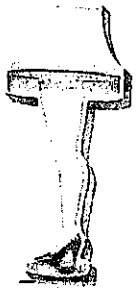
Referring Physician _____ How did you hear about us? _____

Vascular History	**Yes**	**No**	**Vein Treatment History**	**Yes**	**No**
Do you have or have you ever been diagnosed with:			Have you ever been treated for varicose veins with:		
Varicose Veins			Sclerotherapy		
Phlebitis (vein redness/tenderness)			Laser Therapy (spider veins)		
Blood clot			Phlebectomy		
Deep Vein Thrombosis (DVT)			Vein stripping surgery		
Diabetes (Type 1 or Type 2)			RF ablation		
Saphenous vein reflux			VeaSeal Closure System		
Do you experience any of the following in your legs?	**Yes**	**No**	**Personal History**	**Yes**	**No**
Aching/ Pain			Pregnancies? How many? ____		
Heaviness			Does your work require:		
Tiredness/Fatigue			Prolonged sitting		
Itching/Burning			Prolong standing		
Swelling			Heavy lifting? How many lbs __		
Throbbing					
Restless legs					
Skin Ulcers					

Patient Name_____

Date:_____/_____/_____

Face photos taken:_____
Leg photos taken:_____



Weight:_____

Height:_____

RR:_____

HR:_____

BP:_____/_____

SpO2:_____%

	L	R
Thigh	_____	**Thigh** _____
Calf	_____	**Calf** _____
Ankle	_____	**Ankle** _____

Floor To Knee_____

Floor to Thigh_____