

**CENTRAL TEXAS VEIN CENTER**

**Female Patient Health History Form**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Did a physician refer you? If so, whom? \_\_\_\_\_

Please briefly describe your chief complaint \_\_\_\_\_

---

**Past Medical History**

1. Have you ever had vein surgery, vein injections, laser treatments, or any other type of vein treatment?

Yes No

If yes, what type and when? \_\_\_\_\_

2. Have you had any tests done or evaluations of your veins? Yes No

If yes, who, what, and when? \_\_\_\_\_

3. Have you ever had a blood clot? Yes No

If yes, what leg and when? \_\_\_\_\_

Were you treated with a blood thinner (Heparin, Coumadin)? Yes No

3. Have you ever had phlebitis (inflammation of the vein)? Yes No

If yes, what leg and when? \_\_\_\_\_

**Child Rearing History**

1. Are you presently pregnant? Yes No

2. How many times have you been pregnant? \_\_\_\_\_

3. Do you intend to have any more children? Yes No

**Family Medical History**

1. Does anyone in your family have varicose veins, spider veins, or leg ulcers?

Yes No

If yes, who? \_\_\_\_\_