

**CENTRAL TEXAS VEIN CENTER**

**Male 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 ever treated with a blood thinner (Heparin, Coumadin)? Yes No

4. Have you ever had phlebitis (inflammation of a vein)? Yes No

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

**Family Medical History**

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

Yes No

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