GVS Georgia Vein Specialists

790 Church Street
Suite 400
Marietta, GA 30060

6002 Professional Parkway
Suite 260
Douglasville, GA 30134

Phone: 678.626.0019

Website: www.gavein.com

PATIENT MEDICAL HISTORY

Last Name	**First**	**MI**

Age	**Sex** ☐ **Male** ☐ **Female**	**Occupation**

Were you referred by your physician? ☐ Yes ☐ No	**Referring/Primary Physician** (must include First and Last name)

SYMPTOMS: (please check all that apply)

	Right Leg	Left Leg		Right Leg	Left Leg
☐ **Pain/Aching in Leg**	☐	☐	☐ **Itching/Burning**	☐	☐
☐ **Leg Cramps**	☐	☐	☐ **Ulcers/ Ulceration**	☐	☐
☐ **Skin Changes**	☐	☐	☐ **Leg/Restlessness**	☐	☐
☐ **Throbbing**	☐	☐	☐ **Tiredness/Fatigue**	☐	☐
☐ **Swelling**	☐	☐			

Additional Comments: _____

Do you take any medications to relieve your symptoms? Yes ☐ No ☐	**Please list any medication that you take to relieve your symptoms:**
Are your symptoms worse with: ☐ Prolonged standing/sitting ☐ Menstrual cycle ☐ N/A	**Are you symptoms relieved with?** ☐ Rest ☐ Elevation of leg ☐ N/A

How many years have you had this/these symptoms?	**Have you worn support or compression hose?** ☐ Yes ☐ No	**If yes, how long?** ☐ 1-3 months ☐ 3-6 months ☐ > 6 months

What made you decide to seek treatment at this time?

Additional comments about your symptoms

FEMALES ONLY ☐ My symptoms are worse before or during menstrual cycle ☐ I am pregnant or actively trying to become pregnant ☐ I am on hormone therapy (i.e. estrogen, premarin, provera, birth control, etc.)	**Number of pregnancies?**	**Number of deliveries?**

Please list any allergies that you have:	**Please list all medications that you are currently taking, including non-prescription:**

Do you have any family history of varicose veins/spider veins? (please check all that apply)

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle

Have you had any previous vein treatment therapy? (please check all that apply) ☐ Vein Surgery ☐ Injections ☐ Laser ☐ Vein Evaluations ☐ Other _____	**Where did you have your vein treatment?**

MEDICAL HISTORY (please check all that apply)

☐ No History	☐ Leg Ulcer	☐ Stroke	☐ Seizures	☐ Other _____
☐ Blood Clots - Leg	☐ Leg Swelling	☐ Diabetes	☐ Cancer	
☐ Blood Clots - Lung	☐ High Blood Pressure	☐ Asthma	☐ Hepatitis	
☐ Leg Injury	☐ Heart Disease	☐ Bleeding Disorder	☐ HIV (AIDS)	

Have you ever been hospitalized for any of these conditions? ☐ Yes ☐ No If yes, please explain: _____

Patient Signature	**Date**