Patient Name: _____ **Date:** _____
D.O.B_____ **Height**_____ **Weight**_____
Insurance Co._____

Brief Medical History

What brings you in today? _____

_____

Please check any of the following conditions that apply to you personally:

No past medical problems
Arthritis_____
High Blood Pressure_____
HIV/AIDS_____
Hepatitis A___ B___ C___
Liver Disease_____
Stroke_____
Clotting/Bleeding disorder_____

☐ Blood clots in the leg(s)_____
☐ Diabetes_____
☐ Heart Disease_____
☐ Kidney Disease_____
☐ Lung Disease_____
☐ Thyroid Disease:Hypo or Hyper_____
☐ Other_____

Please list all medications or supplements you are taking, including hormones, vitamins, and herbal preparations. Please indicate the dose and number of times you take it each day, if known.

☐ **No current medications, vitamins, or supplements**

_____

_____

_____

_____

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to any medications, dyes, or foods? ☐ No Known Allergies

_____

_____

_____

Do you smoke? ☐ Yes ☐ No If yes, how much per day?_____

Do you exercise? ☐ Yes ☐ No What activity and how often? _____

Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No

Have you taken analgesics (like Advil or Tylenol) **to relieve your symptoms?** ☐ Yes ☐ No

Have you ever worn compression stockings or support hose/tights (even for short periods of time, such as during pregnancy or after surgery or childbirth)**?** ☐ Yes ☐ No

Ladies: Are you currently pregnant, nursing, or attempting to become pregnant? ☐ Yes ☐ No