Austin Vein & Vascular Clinic
Dr. Neal T. Foley, M.D.
Board Certified, American Board of Thoracic Surgery
Westlake Hills Medical Center
5656 Bee Caves Road, Suite H-201
Austin, TX 78746

Female Patient Health History Form

Name:_____ Age:_____ Date:_____

Please briefly describe your chief complaint: _____

_____

Who is your Primary Care Physician? _____

PAST MEDICAL HISTORY

Have you ever had vein surgery, vein injections, laser treatment, or other type of vein treatment?

Yes No If yes, what type and when?_____

Have you had any tests done or evaluations of your veins?

Yes No If yes, who, what, and when?_____

Have you ever had a blood clot?

Yes No If yes, what leg and when?_____

- If yes, were you treated with a blood thinner (Heparin, Coumadin)? Yes No

Have you ever had phlebitis (inflammation of a vein)?

Yes No If yes, what leg and when?_____

CHILD REARING HISTORY

Are you presently pregnant? Yes No How many times have you been pregnant?_____

If of childbearing age, do you intend to have any more children? Yes No

FAMILY HISTORY

Does anyone in your family have varicose veins, spider veins, or leg ulcers? Yes No

Who? _____

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CURRENT HISTORY

Do you currently have any of the following:

Heart Disease	Yes	No	High blood pressure	Yes	No
Lung Disease	Yes	No	Arthritis	Yes	No
Allergies *(medicines, latex, tape, shellfish, etc.)*			Yes	No	

➔ If yes, please specify: _____

Please list any medications you take including prescription and over-the-counter._____

_____

Do you experience any of the following with your legs:

Aching/pain	Yes	No	Tiredness/fatigue	Yes	No
Heaviness	Yes	No	Itching/burning	Yes	No
Swollen ankles	Yes	No	Cramping/throbbing	Yes	No

Do you have any of the following (circle): Varicose veins Spider veins For how long?_____

Have your veins gotten worse in recent months? Yes No

Do you have discomfort in your legs? Yes No How long have you had leg discomfort? _____

If you have leg discomfort, what methods do you use to relieve it (*circle*):

Compression stockings/support hose: *Do they provide relief?* Yes No

➔ If yes, how long have you worn them? _____

Leg Elevation	Walking	Cold Packs	Tylenol	Pain meds
Warm Soaks	Ibuprofen	Aspirin	Exercise	