



Patient History Sheet

The Vein Treatment Center ~ Dr. William P. Kalchoff and Dr. Grady L. Hallman

Name: _____ Date of Birth _____ Age _____ Sex M/F

What type of problem do you wish to evaluate? _____

When did this problem begin? _____

What are your symptoms? _____

Have you ever had treatment for this problem? YES/NO What kind _____

Does anyone in your family have the following?

Varicose Veins _____ Leg Ulcers _____ Spider Veins _____

Do you wear support hose? YES/NO Do they provide relief? YES/NO

Do you smoke? YES/NO How many years _____ How many packs a day _____

Do you have any Allergies? YES/NO If yes, what kind: _____

Do you have any of the following?

High blood pressure Y/N Diabetic Y/N

Heart disease Y/N Bladder problems Y/N

Cardiac pacemaker Y/N Lung problems Y/N

Arthritis Y/N Skin itchiness Y/N

Stroke Y/N Dry skin Y/N

HIV infection Y/N Are you pregnant Y/N

Hepatitis Y/N Are you breast feeding Y/N

Stomach/Bowel problems Y/N Other concerns: _____

History of cancer Y/N _____

Liver/Kidney disease Y/N

Patient signature: _____ Date: _____