DRS. YOUNG & WOUTERS
CALGARY VEIN & LASER

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____ **AHC#:** _____

E-MAIL ADDRESS: _____ **WEBSITE:** _____

How did you hear about us: ☐ **newspaper** ☐ **yellow pages** ☐ **other** ☐ **friend (name)** _____

☐ **conference/exhibitions** ☐ **Referring physician (name)** _____

OCCUPATION: _____ **HT:** _____ **WT:** _____

1. Reason for consultation: ☐ Pain ☐ Cosmetic ☐ Prevention ☐ Swelling ☐ Other _____
2. If pain, type is: ☐ burning ☐ heaviness ☐ fatigue ☐ Left leg ☐ Right leg ☐ Both Legs
3. Family history of varicose veins? ☐ Mother ☐ Father Family history of blood clot or phlebitis? _____ (Y/N)
4. Have you ever had phlebitis or a blood clot? _____ (Y/N) When? _____ ☐ Hospitalized? (where) _____

   How were you treated? ☐ Blood thinners (name) _____ Tests done? ☐ venogram ☐ ultrasound
5. Age you first noticed your varicose veins/spider veins? _____
6. Do you get pain in your legs prior to or during your menstrual period? _____ (Y/N) **see reverse**
7. Number of pregnancies? ____ Number of deliveries: ____ Are you currently pregnant? ____ (Y/N) Are you breastfeeding: __ (Y/N)
8. Have you had any leg injuries? (please specify) _____
9. Do you smoke? _____ (Y/N) How much (per day)? _____
10. Illnesses:

☐ Tuberculosis	☐ Heart problems	☐ Other (List below)
☐ Diabetes	☐ High Blood Pressure	_____
☐ Cancer	☐ Arterial Problems	_____
☐ HIV/AIDS	☐ Hepatitis	_____
☐ Thyroid	☐ Arthritis	_____

11. List Surgeries & date — Family History of above (List below)

    _____ _____

    _____ _____
12. Have you ever had a transfusion? _____ (Y/N) Year? _____
13. List medication presently taking:

    _____ _____

    _____ _____
14. Do you have: ☐ Asthma ☐ Hay Fever ☐ Eczema
15. Do you have allergies to: ☐ Aspirin ☐ Iodine ☐ Tapes/Bandages ☐ Xylocaine (Dental Freezing) ☐ Seafood

    List allergies to other medication or food etc. _____ _____ _____

    _____ _____ _____
16. Any previous treatment for varicose veins? ☐ Injections ☐ Surgery

SEE OVER

MEDICAL HISTORY QUESTIONNAIRE

FOR FEMALES ONLY

1. Do you have leg pain prior to or during your menstrual period? ☐ yes ☐ no
2. Are your varicose veins and/or leg pain worse during your period? ☐ yes ☐ no
3. Do you have painful intercourse a week prior to your period? ☐ yes ☐ no
4. Do you have frequency of urination, constipation or diarrhea during your period? ☐ yes ☐ no
5. Do you have a sense of groin pressure during menstruation? ☐ yes ☐ no
6. Do you have a sensation of fullness of the buttocks during your period? ☐ yes ☐ no

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Are you interested in receiving information on any of the following services?

- ☐ Botox
- ☐ Brown pigmented spots or age spots on the hands, face, or other areas of the body.
- ☐ Chemical peels of the face or hands (Glycolic, Aspirin, Blue Peel etc.)
- ☐ Diamond Peel of face, hands, neck etc.
- ☐ Facial Veins
- ☐ Skin care program (Medique, Dr. Perricone, Obagi etc.)
- ☐ Acne or skin problems
- ☐ Skin tag or mole removal
- ☐ Tissue Fillers (Collagen, Restylane, Artecoll etc.)
- ☐ Laser Hair removal
- ☐ Esthetic services (manicures, pedicures, facials, waxing)
- ☐ Facial resurfacing
- ☐ Rosacea