

## MEDICAL HISTORY FORM

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications/Herbal Supplements/ Over the Counter/Accutane or RetinA \_\_\_\_\_

Previous Surgeries \_\_\_\_\_

**MEDICAL HISTORY:** Please check if **you** have a current or past history of any of the following:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Fainting spells     | <input type="checkbox"/> Heart failure             | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Anticoagulant use  |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Difficulty healing | <input type="checkbox"/> Nervous Disorder   |
| <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Fluid retention           | <input type="checkbox"/> Keloid scarring    | <input type="checkbox"/> Pregnancy          |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Leg Swelling              | <input type="checkbox"/> Bleeding problems  | <input type="checkbox"/> Smoking            |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Arthritis/Lupus           | <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Phlebitis          |   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Leg ulcers         |   |

**SUN EXPOSURE HISTORY:**

When were you last exposed to the sun (including tanning bed)? \_\_\_\_\_

Are you using self – tanning lotion? YES/NO How recently was it applied? \_\_\_\_\_

Are you planning a trip or vacation in the sun within the next 30 days? YES/NO When? \_\_\_\_\_

Which best describes your skin when exposed to sun **without protection** for about 1 hour?

- |  |  |
|--|--|
| <input type="checkbox"/> Always burns, never tans        | <input type="checkbox"/> Never burns, always tans        |
| <input type="checkbox"/> Always burns, sometimes tans    | <input type="checkbox"/> Hispanic, Asian, Middle Eastern |
| <input type="checkbox"/> Sometimes burns, sometimes tans | <input type="checkbox"/> African-American                |

**FOR VEIN PATIENTS ONLY:**

Do you experience leg pain or aching? YES/NO Which leg? RIGHT/LEFT/BOTH

When do you feel pain? All day Every day At end of the day After standing for a long time During menses

What helps your pain? Nothing Bed rest Elevation Compression stockings Medication Exercise Heat

Do you exercise? Never Rarely Monthly 1 to 2 times/wk 3 to 4 times/wk 5 to 6 times/wk

What type of exercise? \_\_\_\_\_

Average hours per day spent: Sitting in one place \_\_\_\_\_ Standing in one place \_\_\_\_\_