VEIN SOLUTIONS

MEDICAL CLINIC

MEDICAL HISTORY QUESTIONNAIRE

Please take a few minutes to answer the following questions carefully as this assists us in preparing for your assessment. The information from this Questionaire may be used for research purposes. Your personal details will be withheld. Please tick what is correct. If you are not sure about the answer, leave it blank and ask the Doctor at your consultation.

Surname:	Title: Mr / Mrs / Ms / Miss
First Name:	Date of Birth: / /
Phone No: (H)	(M)
Address:	
Email:	
Pension/HCC No: ☐☐☐ ☐☐☐ ☐☐☐☐	Exp: /
Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐	
Expiry date: / /	Ref No:
Family Doctor Name:	
Address:	
Suburb:	Postcode: .....
Phone:	

How did you find out about us?

☐ Friend ☐ Doctor Referral ☐ Magazine ☐ Word of Mouth ☐ Internet

Your Current Complaint *(Code YCC)*

1. Are you consulting for:

- ☐ a. Varicose veins of the legs
- ☐ b. Spider veins of the leg
- ☐ c. Leg ulcers
- ☐ d. Recurrence of the veins after an operation
- ☐ e. Recurrence of the veins after injections
- ☐ f. Recurrence of the veins after Laser
- ☐ g. Pelvic congestions
- ☐ h. Varicose veins of the vagina
- ☐ i. Lymphatic problem of the legs
- ☐ j. Check-up
- ☐ k. Other:

…….

(Code 1M)

Your Symptons *(Code YS)*

2. Indicate which of the following problems you have experienced:

- ☐ a. Pain in your legs
- ☐ b. Heaviness in the legs
- ☐ c. Bursting pain in the calf after exercise
- ☐ d. Burning sensation in the calf
- ☐ e. Night cramps in the legs
- ☐ f. Itchiness in the legs
- ☐ g. Leg rash
- ☐ h. Swelling in the legs
- ☐ i. Tiredness in the legs
- ☐ j. Restlessness in the legs
- ☐ k. Other:

.....

(Code 2L)

3. If you experience pain in your legs: *(Code 3A)*

a. Does your pain get worse:

Yes	*No*		
☐	☐	a.	before your menstrual periods
☐	☐	b.	after extended periods of standing
☐	☐	c.	with heat
☐	☐	d.	at the end of the day
☐	☐	e.	following exercise and walking
☐	☐	f.	early mornings

Other: ….....

….....

….....

b. Does the pain get better by: *(Code 3B)*

Yes	*No*		
☐	☐	a.	rest
☐	☐	b.	elevating the legs
☐	☐	c.	elastic stockings
☐	☐	d.	medication: ….....
☐	☐	e.	exercise and walking
☐	☐	f.	when you stand up

Other: ….....

….....

….....

Onset of Veins *(Code OV)*

4. When did your veins occur?

Yes

a. Age: .....

☐ b. Since childhood

☐ c. After taking the contraceptive pill

☐ d. Before pregnancy

☐ e. During pregnancy

☐ f. After pregnancy (while breast feeding).

Specify which pregnancy: .....

☐ g. After menopause

☐ h. After an operation

☐ i. After trauma

Other: .....

.....

5. *Ladies only:* Do you suffer from: *(Code 5PC)*

Yes

☐ a. Heaviness in the lower abdomen .....

☐ b. Pain in the lower abdomen .....

☐ c. Burning sensation in the groin .....

☐ d. Difficult and painful intercourse .....

☐ e. Hemorrhoids .....

☐ f. Frequent urination .....

☐ g. Constipation .....

Past Venous History *(Code PVH)*

6. Have you had any of the following:

Yes *No*

☐ ☐ a. Phlebitis *(inflammation of a vein)* .....

☐ ☐ b. DVT *(blood clot in a deep vein)* .....

☐ ☐ c. Pulmonary embolism *(blood clotinthelung)*.....

☐ ☐ d. Ulcer of the legs.....

☐ ☐ e. Bleeding disorder .....

☐ ☐ f. Easing bruising .....

☐ ☐ g. Required Warfarin or had injections in the tummy for any reason

.....

7. Have you had previous treatments for your veins?

Yes *No* *(Code 7Y 7N)*

☐ ☐

if yes, with what method?

☐ a. Injection

☐ b. Operation

☐ c. Laser

☐ d. Other: .....

by whom and when?

.....

.....

Did you have any problems afterwards?

.....

.....

Were you happy with the overall results?

.....

.....

Past Medical History *(Code PMH)*

8. Do you have a history of:

Yes	*No*		
☐	☐	a.	HIV / AIDS .....
☐	☐	b.	Hepatitis – *A, B, or C, please indicate* .....
☐	☐	c.	Blood transfusions .....
☐	☐	d.	Asthma .....
☐	☐	e.	Diabetes – *on Insulin, tablets, or diet controlled?* .....
☐	☐	f.	High blood pressure .....
☐	☐	g.	Seizures, convulsions or epilepsy .....
☐	☐	h.	Stroke .....
☐	☐	i.	Bad circulation .....
☐	☐	j.	Cancer .....
☐	☐	k.	Arthritis or other types of autoimmune disease *(e.g. Lupus)* .....
☐	☐	l.	Thyroid problems – *please explain* .....
☐	☐	m.	Heart disease .....
☐	☐	o.	Migraine .....
☐	☐	p.	Hole in the heart? .....

Other medical problems .....

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Gynaecological History *(Ladies only)* *(Code GH9)*

9. **How many times have you been pregnant?** .....

(include any termination or miscarriage) .....

10. **How many children do you have?** .....*(Code GH10)*

		Yes	*No*
11.	**Are you pregnant?** *(if applicable)*	☐	☐
12.	**Are you planning a pregnancy soon?** *(if applicable)*	☐	☐
13.	**Are you currently breast feeding?** *(if applicable)*	☐	☐
14.	**Have you had a hysterectomy?** (if applicable)	☐	☐

if yes what year? .....

		Yes	*No*
15.	**Are you taking the Pill?** (if applicable)	☐	☐

if yes which one? .....

for how long? .....

		Yes	*No*
16.	**Hormone Replacement Therapy?** (if applicable)	☐	☐

if yes which one? .....

for how long? .....

Surgical History

17. **Please name all operations you have had with relevant year**

.....

.....

.....

.....

Family History *(Code FH)*

18. Do you have a family history of:

Yes *No*

- ☐ ☐ a. Varicose vein problems .....
- ☐ ☐ b. Spider veins .....
- ☐ ☐ c. Phlebitis (inflammation of the vein).....
- ☐ ☐ d. Blood clots .....
- ☐ ☐ e. Bleeding disorders .....
- ☐ ☐ f. Leg ulcers .....
- ☐ ☐ g. Other problems affecting the veins or circulation? .....

  .....

Psychological History *(Code PH)*

19. Do you suffer from:

Yes *No*

- ☐ ☐ a. Anxiety .....
- ☐ ☐ b. Panic attacks .....
- ☐ ☐ c. Claustrophobia .....
- ☐ ☐ d. Needle phobia .....
- ☐ ☐ e. Other psychological or psychiatric disorder .....

  .....

Social History

20. About you:

- ☐ a. single
- ☐ b. married
- ☐ c. smoker..... / day
- ☐ d. regular alcohol ..... / day
- ☐ e. social drinker
- ☐ f. occupation .....

  .....

Medications

21. Regular Medications .....

.....

.....

.....

.....

Are you taking fish oil extract? *Yes* ☐ *No* ☐

22. Are you taking Iron Tablets?

Yes ☐ *No* ☐ *(Code 24Y 24N)*

If yes for how long? .....

For what reason? .....

23. Do you take aspirin or anti-inflammatory drugs?

Yes ☐ *No* ☐ *(e.g. Voltaren, Naprosyn, etc)*

Allergies *(Code A1Y A1N)*

24. Have you had any of the following allergic reactions?

Yes *No*

☐ ☐ a. Eczema .....

☐ ☐ b. Hives .....

☐ ☐ c. Hay fever .....

☐ ☐ d. Anaphylactic shock (severe life threatening allergic reaction)

if yes please explain what happened .....

.....

.....

.....

25. Do you have an allergy to any of the following?

If you answer "'Yes' to any of the following, please explain what happens if you take them

Yes *No*

☐ ☐ a. Foods .....

☐ ☐ b. Local anaesthetic .....

☐ ☐ c. Tapes .....

Other .....

.....

.....

26. What are your feelings towards surgery on your veins?

☐ a. Don't mind

☐ b. If really necessary

☐ c. Opposed

27. Are there any pending travel arrangements?

Yes *No*

☐ ☐ *(if yes please give details)* .....

.....

.....

.....

28. Have you had any problems with your legs with travel?

Yes *No*

☐ ☐ *(if yes please explain)* .....

.....

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Thank you for your time!

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