



Medical History

Patient name: _____ Height: _____ Weight: _____

Medical conditions:

Number of pregnancies and live births _____

Medications and Herbals (incl date begun)	Dosage and Frequency

Do you take Minocycline? _____

Allergies? If yes, what happens? _____

Previous Vein Interventions	With Whom & Date
Surgery	
Endovenous Laser or Radiofreq Ablation	
Sclerotherapy	

Is there any family history of Varicose Veins? _____

Do you smoke (If so, how much?) _____ Do you drink (If so, how much?) _____

If you have symptoms (aching heaviness, swelling, restless legs) due to your veins, please tell us so we can give you an additional form. This will help us in providing you with the best medical care. We thank you for taking the time to answer them.