VEIN REMEDIES – 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 questionnaire 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:	First Name:
Home Telephone Number:	Date of Birth dd/mm/yy ...../...../.....
Sex:	
Address:	
Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Exp:	
Name & Address of your Family Doctor:	
How did you find out about us?	
By which method during working hours would you like to be contacted for booking information? Phone: ..... Fax: ..... Email: ..... Mobile/SMS: ..... Mail: ..... *(Please insert mailing address if not the same as above)*	

1. Your Current Complaint (Code 1y)

Are you consulting for:

- ☐ a. Varicose veins of the legs: *which leg is worse* L ☐ R ☐
- ☐ b. Spider veins of the legs
- ☐ c. Facial veins and broken capillaries ▼ *go to section 4*
- ☐ d. Leg ulcers
- ☐ e. Recurrence of the veins after an operation
- ☐ f. Recurrence of the veins after injections
- ☐ g. Recurrence of the veins after Laser
- ☐ h. Pelvic congestion
- ☐ i. Varicose veins of the vagina
- ☐ j. Lymphatic problem of the legs
- ☐ k. Check-up
- ☐ l. Other

2. Your Symptoms (Code 2n/y)

Indicate which one 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

3. If you experience pain in your legs: (Code 3n/y)

3a. Does your pain get worse:

Yes	No		
☐	☐	a.	Before your menstrual periods
☐	☐	b.	After long periods standing
☐	☐	c.	With heat
☐	☐	d.	At the end of the day
☐	☐	e.	Following exercise and walking
☐	☐	f.	Early mornings

Other: .....

3b. Is the pain reduced by:

Yes	No		
☐	☐	a.	Rest
☐	☐	b.	Elevating the legs
☐	☐	c.	Elastic stockings
☐	☐	d.	Medication:
☐	☐	e.	Exercise and walking
☐	☐	f.	Standing up

Other: .....

4. Onset of Problem Veins (Code 4o)

a. Age the veins occured .....
❑ 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 5p)

Yes	No		
❑	❑	a.	Heaviness in the lower abdomen
❑	❑	b.	Pain in the lower abdomen
❑	❑	c.	Burning sensation in the groin
❑	❑	d.	Difficult or painful intercourse
❑	❑	e.	Hemorrhoids
❑	❑	f.	Frequent urination
❑	❑	g.	Constipation

6. Past Venous History (Code 6v)

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 clot in the lung*)
❑	❑	d.	Ulcer of the legs If so: where and when .....
❑	❑	e.	Bleeding disorder
❑	❑	f.	Easy bruising
❑	❑	g.	Required Warfarin, (tablets to thin the blood) or had injections in the tummy Reason: .....

7. Have you had previous treatments for your veins? (Code 7n/y)

Yes ❑ No ❑

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?

.....

.....

8. Past Medical History (Code n/y)

Do you have a history of:

Yes	No		
❑	❑	a.	HIV / AIDS
❑	❑	b.	Hepatitis – A, B, or C, please indicate
❑	❑	c.	Blood transfusions When: .....
❑	❑	d.	Asthma
❑	❑	e.	Diabetes – on Insulin, tablets, or diet controlled?
❑	❑	f.	High blood pressure
❑	❑	g.	Seizures, convulsions or epilepsy
❑	❑	h.	Stroke
❑	❑	i.	Cancer Type: .....
❑	❑	j.	Arthritis or other types of autoimmune disease (e.g. Lupus) Where: .....
❑	❑	k.	Thyroid problems – please explain
❑	❑	l.	Heart disease

Other medical problems: .....

Gynaecological History

(Ladies only)

9. How many times have you been pregnant?
(Include any termination or miscarriage)

10. How many children do you have? – gender and ages: .....

	Yes	No	
11g. Are you pregnant? (*if applicable*)	❑	❑	
12g. Are you planning a pregnancy soon? (if applicable)	❑	❑	
13g. Have you had a hysterectomy? (if applicable)	❑	❑	*if yes what year?* .....
14g. Are you taking the Pill? (if applicable)	❑	❑	*if yes which one?* .....
			for how long? .....
15g. Hormone Replacement Therapy? HRT (*if applicable*)	❑	❑	*if yes which one?* .....
			for how long? .....

16. Surgical History

Please name all operations you have had with relevant dates

.....

.....

.....

.....

.....

17. Family History **(Code 17n/y)**

Do you have a family history of:

Yes	No			Yes	No		
❑	❑	a	Varicose vein problems	❑	❑	e	Bleeding disorders
❑	❑	b	Spider veins	❑	❑	f	Leg ulcers
❑	❑	c	Phlebitis (inflammation of the veins)	❑	❑	g	Other problems affecting the veins or circulation?
❑	❑	d	Blood clots				

If you have indicated Yes to any of the above, who did it affect, and did they have surgery?: .....

18. Psychological History **(Code 18n/y)**

Do you suffer from:

Yes	No		
❑	❑	a.	Anxiety
❑	❑	b.	Panic attacks
❑	❑	c.	Claustrophobia
❑	❑	d.	Needle phobia
❑	❑	e.	Other psychological or psychiatric disorder

19. Social History

About you:

❑ a. Single
❑ b. Married
❑ c. Smoker..... /day
if in past, when and how many?: .....

❑ d. Regular alcohol..... /day
❑ e. Social drinker
❑ f. Occupation .....

20. Medications

Regular Medications and Dosage .....

.....

.....

21. Are you taking Iron Tablets?

Yes	No
❑	❑

If yes for how long? .....

For what reason?.....

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

Yes No

❑ ❑ (*E.g. Voltaren, Naprosyn, etc*)

23. Allergies **(Code 23n/y)**

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 .....

.....

24. Do you have an allergy to any of the following? **(Code 24n/y)**

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

Yes No

❑ ❑ a. Foods .....

❑ ❑ b. Iodine .....

❑ ❑ c. Shellfish .....

❑ ❑ d. Injections used when taking X-Rays .....

❑ ❑ e. Sulfur drugs .....

❑ ❑ f. Local anaesthetic .....

❑ ❑ g. Tapes .....

Other: .....

.....

.....

25. Do you have any airline travel planned in the next 6 months? **(Code 26n/y)**

Yes No

❑ ❑

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

.....

.....

26. Have you had any problems with your legs with travel? **(Code 27n/y)**

Yes No

❑ ❑

(*if yes please explain*) .....

.....

.....

Thank you for your time!

YOU MUST BRING THIS COMPLETED FORM TO YOUR FIRST CONSULTATION

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