North Shore VeinCenter

Mark Schwartz, MD, FACS, RPVI

Patient History

Patient Name: _____ Occupation: _____

Email address: _____

Height: _____ Weight: _____ D.O.B:_____

How did you hear about us? _____

Primary care doctor _____

How long have you had this problem (please estimate)? # of Years _____ # of Months _____

Have you ever had treatment for your veins in the past? ⬭ No ⬭ Yes if yes, explain:

_____

_____

Please **check** if you have even been diagnosed with or treated for the following:

- ⬭ Deep Vein Thrombosis
- ⬭ Pulmonary Embolus
- ⬭ Phlebitis/Blood Clots
- ⬭ High Blood Pressure
- ⬭ Heart Disease
- ⬭ Hepatitis
- ⬭ Diabetes
- ⬭ Asthma
- ⬭ Lung Disease/COPD
- ⬭ Arthritis
- ⬭ HIV/AIDS
- ⬭ Bleeding disorder
- ⬭ Peripheral vascular disease
- ⬭ Heart valve disease
- ⬭ Stroke
- ⬭ Other _____
- ⬭ None

Any prior Surgical Procedures? _____

Have you ever been tested for or found positive for a Patent Foramen Ovale or Atrial Septal Defect?

⬭ Yes ⬭ No

Please **check** if you have recently experienced any of the following:

- ⬭ Night Sweats
- ⬭ Unexplained Weight Loss
- ⬭ Persistent Cough
- ⬭ Loss of appetite
- ⬭ Fever
- ⬭ Hemoptysis (coughing up blood)
- ⬭ Chest pain
- ⬭ Shortness of breath
- ⬭ Palpitations
- ⬭ None

North Shore Vein Center
One Hollow Lane, Suite 210
Lake Success, NY 11042

Tel: 516-869-VEIN (8346)
Fax: 516-773-6133
www.NorthShoreVein.com

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Are you currently taking any medications? ⬭ Yes ⬭ No

If yes, please list all prescribed and over-the –counter, vitamins and herbals: _____

_____

_____

_____

Are your allergic to any medications/foods/Latex? ⬭ Yes ⬭ No

If yes, please list: _____

Do you take any blood-thinning medication (e.g. Coumadin, Plavix or Aspirin)? ⬭ Yes ⬭ No

If yes, please list _____

Do you smoke? ⬭ Yes ⬭ Yes-but not anymore (stopped _____yrs ago) ⬭ No/Never

If yes, how many packs per day? _____

Do you consume alcohol? ⬭ Yes ⬭ Yes, socially, but not regularly ⬭ No/Never

Is there a family history of blood clots? ⬭ Yes ⬭ No

If yes, please explain: _____

Do you suffer from asthma or recurring migraine headaches? ⬭ Yes ⬭ No/Never

Females Only:

Are you pregnant or trying to become pregnant? ⬭ Yes ⬭ No

Are you currently breast-feeding? ⬭ Yes ⬭ No

Are you taking hormones or birth control pills (ex: Estrogen, Progesterone or Tamoxifen)? ⬭ Yes ⬭ No

If yes, please list: _____

PHYSICIAN ONLY

Left leg: GSV_____ SSV_____ AASV_____ Perforators_____

Right leg: GSV_____ SSV_____ AASV_____ Perforators_____

Blood Pressure: _____ / _____ Notes: _____

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