SpotlessVeinCare
Dr. Hormoze Goudarzi
MD, PA

Vein Consultation Questionnaire

Date:_____

Patient Name:_____ Birth Date:_____

Primary Care Physician:_____

Drug Allergies:_____

Current Medications:_____

_____

Currently on Blood Thinner? Yes: ☐ No: ☐ N/A: ☐

Currently on Hormones (Birth Control, Hormone Replacement)? Yes: ☐ No: ☐ N/A: ☐

Of Pregnancies_____ # Of Miscarriage _____

Past Medical History: (Cancer, Diabetes, Heart Disease, Strokes, Hypertension, Thyroid Disorders, Kidney Disease)_____

_____

Leg trauma: _____

Previous Surgery:_____

_____

Family Medical History: (Cancer, Diabetes, Heart Disease, Strokes, Hypertension, Kidney Disease)_____

_____

Family History of Varicose Veins: Yes: ☐ No: ☐ N/A: ☐

Family History of Clotting disorders: Yes: ☐ No: ☐ N/A: ☐

What Kind Of Symptoms Do You Have (check all that apply):

Pain ☐	Night Cramps ☐	Heaviness ☐	Pigmentation ☐	Bleeding Veins ☐
Swelling ☐	Restlessness ☐	Burning ☐	Tenderness ☐	Other:
Aching ☐	Fatigue ☐	Tingling ☐	Ulceration ☐	

How did you hear about us?_____