HEALTH QUESTIONNAIRE

Please fill in this form thoroughly. All of your medical history is important in managing your care. Do not exclude any information because you feel it is not important.

Name: _____ DOB: _____ Date: _____

Sex: ☐ Male ☐ Female ☐ Other (please specify) _____

Weight (kg): _____

Height (cm): _____

Allergies

Do you have any allergies? ☐ Yes ☐ No

- If yes, provide details:

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Medication

Do you take Aspirin or any other medication to thin the blood ☐ Yes ☐ No

- If yes, provide name/dose: _____

Are you currently taking any hormonal medication? ☐ Yes ☐ No

- If yes, please indicate:
  - ☐ Hormone Replacement Therapy (HRT)
  - ☐ Oral Contraceptive Pill (OCP)
  - ☐ Other
- Please provide name/dose: _____

Do you take any acid blockers for indigestion/reflux/stomach ulcers (I.e. Nexium, Somac, Zantac, Losec)? ☐ Yes ☐ No

What other medications do you take? (Please include herbal supplements)

Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

Please tick any signs/symptoms you have in your legs (check all that apply)

Right Leg	Left Leg
☐ No right leg symptoms	☐ No left leg symptoms
☐ Spider Veins	☐ Spider Veins
☐ Bulging Veins	☐ Bulging Veins
☐ Swelling	☐ Swelling
☐ Itchiness	☐ Itchiness
☐ Eczema	☐ Eczema
☐ Scarring/Indentation	☐ Scarring/Indentation
☐ Healed Ulcer	☐ Healed Ulcer
☐ Open Ulcer	☐ Open Ulcer
☐ Restless Legs	☐ Restless Legs
☐ Leg cramps at rest	☐ Leg cramps at rest
☐ Painful Legs	☐ Painful Legs

What is the main problem you would like addressed?

_____
_____
_____

Why are you seeking treatment now?

_____
_____
_____

Please describe when you first noticed the changes? (I.e. Year, any preceding event, eg. pregnancy, broken leg; description and progression of symptoms)

_____
_____
_____

What is your level of activity at home and work? (I.e. sitting, standing, exercise)

_____
_____
_____

Have you ever had any of the following?

Past history of Deep Vein Thrombosis (blood clot in deep vein)	☐ Yes	☐ No
Pulmonary Embolism (blood clot in the lungs)	☐ Yes	☐ No
Superficial Thrombophlebitis (blood clot in superficial vein)	☐ Yes	☐ No

Blood condition that makes your blood thicker or more likely to clot ☐ Yes ☐ No

Stroke or Transient Ischemic Attack (TIA) ☐ Yes ☐ No

Vitamin B12 deficiency ☐ Yes ☐ No

Iron deficiency ☐ Yes ☐ No

Multiple miscarriages ☐ Yes ☐ No

- If yes, please indicate how many: _____

History of malignancy (cancer) ☐ Yes ☐ No

- If yes, please provide details: _____
  _____
  _____

Do you have any inflammatory conditions (e.g. psoriasis, arthritis, irritable bowel syndrome, sinusitis, asthma, ankylosing spondylitis, diverticulitis, reflux, fibromyalgia, Parkinson's, hepatitis, lupus)? Please list: _____
_____
_____
_____

Please select any of the following:

Smoker status:

☐ Never smoked
☐ Ex-smoker; how many years did you smoke? _____
☐ Current smoker; how many cigarettes per day? _____

High blood pressure ☐ Yes ☐ No

- If yes, is it well controlled? _____

High cholesterol ☐ Yes ☐ No

- If yes, what is your usual reading? _____

Diabetes ☐ Yes ☐ No

- If yes, Type 1 or Type 2? _____
- Diagnosed for how many years? _____

Asthma ☐ Yes ☐ No

- If yes, have you ever been admitted to hospital for asthma? ☐ Yes ☐ No
- If yes, when was it diagnosed? _____

Epilepsy ☐ Yes ☐ No

- If yes, frequency of seizures? _____

Migraines/headaches ☐ Yes ☐ No

- If yes, other than general pain what are your associated symptoms?

_____

_____

Anxiety ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Any psychiatric conditions ☐ Yes ☐ No

- If yes, please provide details: _____

_____

_____

Peripheral neuropathy (altered sensation in feet) ☐ Yes ☐ No

Thyroid problems ☐ Yes ☐ No

Heart attack ☐ Yes ☐ No

- If yes, when? _____

Chest pain or angina ☐ Yes ☐ No

- If yes, how often? _____

Arrhythmia/abnormal heart rhythms ☐ Yes ☐ No

- If yes, what kind? _____

Heart murmur ☐ Yes ☐ No

Hole-in-the-heart (septal defect aka. PFO [patent foramen ovale]) ☐ Yes ☐ No

- If yes, please provide details (I.e. when diagnosed, tests performed)

_____

_____

Any other heart conditions ☐ Yes ☐ No

- If yes, please provide details: _____

_____

_____

Do you experience claudication (leg cramps when **walking**)? ☐ Yes ☐ No

Do you have arterial disease (blockage or narrowing in an artery)? ☐ Yes ☐ No

- If yes, please provide details: _____

_____

_____

Do you normally take antibiotics before medical or dental procedures? ☐ Yes ☐ No

- If yes, please provide details?_____

Kidney conditions ☐ Yes ☐ No

Liver conditions ☐ Yes ☐ No

Stomach ulcers ☐ Yes ☐ No

Bowel polyps ☐ Yes ☐ No

Conditions affecting the blood ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

- If yes, why? _____

Do you have HIV/AIDS or been exposed through IV drug use, tattoos, or sexual partners? ☐ Yes ☐ No

Do you have any other illnesses not already mentioned? ☐ Yes ☐ No

- If yes, please provide details: _____
  _____
  _____
  _____

Have you ever been admitted to hospital? ☐ Yes ☐ No

- If yes, please provide details (I.e. reason for visit, when) _____
  _____
  _____
  _____
  _____

Family Medical History

Do you have a family history of blood clots, stroke, or sudden death? ☐ Yes ☐ No

- If yes, please indicate who and provide further details: _____
  _____
  _____

Does any family have heart disease? ☐ Yes ☐ No

- If yes, who? _____

Does any family member have a hole-in-the-heart? ☐ Yes ☐ No

- If yes, who? _____

Does any family member have a blood condition? ☐ Yes ☐ No

- If yes, please provide details: _____

Any family history of diabetes? ☐ Yes ☐ No

- If yes, who and which type (Type 1 or Type 2)? _____

Any family history of varicose veins? ☐ Yes ☐ No

- If yes, who? _____

Any family history of Deep Vein Thrombosis, Pulmonary Embolism, or other relevant history? ☐ Yes ☐ No

- If yes, please indicate who and provide further details: _____
  _____
  _____

Investigations/Specialist

Have you had any tests or investigations done in the last 12 months? ☐ Yes ☐ No

- If yes, please indicate who and provide further details: _____
  _____
  _____
  _____

Are you currently under the care of any other specialists? ☐ Yes ☐ No

- If yes, please indicate who and provide further details: _____
  _____
  _____
  _____

Compression Garments

Do you wear compression?

- If yes, where did you buy them? _____
- What kind? (I.e. brand, class or strength if known) _____
- When did you buy your compression garments? _____

Are they comfortable? ☐ Yes ☐ No

Have you ever had custom made compression before? ☐ Yes ☐ No

- If yes, where were they made? _____