MERCYONE | Iowa Heart Center

# Medical History Information

Name: _____ Date of Birth: _____ IHC#: _____

Please list all allergies:

_____ _____

_____ _____

Please list all medications (prescription and non-prescription)

| Medication | Dosage | # of times per day |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you take blood thinning medications?

□ Yes □ No If yes, list reason _____

Do you take birth control pills or hormones?

□ Yes □ No If yes, list _____

## Vein History

Which leg is the most bothersome for you? □ Right □ Left □ Equal

Have you ever had your veins evaluated before? □ Yes □ No

If so, what doctor and when? _____

Do you wear support hose prescribed by a doctor? □ Yes □ No

If yes, what strength and do they provide relief? □ Yes □ No

Have you had any vein surgery? (stripping, laser, or phlebectomy)

□ Yes □ No

If yes, what leg and when? □ Right □ Left _____

Have you ever had any vein injections? □ Yes □ No

If yes, what leg and when? □ Right □ Left _____

Have you ever had any blood clots? (DVT- Deep vein thrombosis)

□ Yes □ No

If yes, what leg and when? □ Right □ Left _____

Were you put on any blood thinning medications? □ Yes □ No

If so, what medications? _____

Have you ever had superficial thrombophlebitis? (Superficial blood clots)

□ Yes □ No

If yes, what leg and when? _____

Have you ever had a pulmonary embolism (PE)? (Blood clot to the lung)

□ Yes □ No

If yes, when? _____

## Past and Current Medical History

Have you ever had any surgery of any kind? □ Yes □ No

If yes, when and what type of surgery? _____

_____

Do you have?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Disease | | | Pacemaker/ Defibrillator | | |
| Lung Disease | | | Hepatitis | | |
| Peripheral Vascular Disease | | | Arthritis | | |
| Leg Ulcer | | | Diabetes | | |
| Asthma | | | Thyroid Disease | | |
| High Blood Pressure | | | Anemia | | |

| | Yes | No |
|---|---|---|
| Do you think you are presently pregnant? | | |
| How many times have you been pregnant? | | |
| Are you currently breastfeeding? | | |

Do you have a history of?

| | Yes | No |
|---|---|---|
| Tuberculosis (TB) | | |
| HIV | | |
| Hepatitis A, B, or C | | |
| Methicillin-Resistant Staphylococcus Aureus (MRSA) | | |