

The Laser Vein Center
at
Ohio Valley Surgical Specialists

Patient Questionnaire

Reminder: Please bring a pair of shorts with you on your first visit to our office.

Please avoid sun exposure and tanning bed use from now until your appointment so that the doctor may make the best possible assessment.

Date: _____

Name: _____ Age: _____ Sex: M F

Height: _____ Weight: _____ Shoe size: _____

How did you hear about our practice? _____

Referring physician: _____ Primary Care Physician: _____

Personal medical history (current complaint)

1. Are you consulting for:

- a. Cosmetic purposes Yes No
- b. Medical reasons Yes No
- c. Both Yes No

2. How many years have you noticed this problem? _____ years

3. Have you ever been treated for this problem?

If yes, by whom and when? _____

With what method?

- _____ Injection
- _____ Stripping
- _____ Laser Type? _____
- _____ Surgery

4. Have you ever been treated for one of the following?

- a. Phlebitis (inflammation of a vein) Yes No
_____ Right leg _____ Left leg
Hospitalization? _____
- b. Leg ulcer Yes No
_____ Right leg _____ Left leg
Hospitalization? _____
- c. Pulmonary embolism/blood clots Yes No

