

Surgical History (List all surgeries including year): _____

Current Medications (Include all over-the-counter or non-prescription drugs): _____

Allergies-Sensitivities (drugs and foods): _____

Family history of (check all that apply and please explain)

VARICOSE VEINS: _____

SPIDER VEINS: _____

BLOOD CLOTS: _____

PHLEBITIS: _____

What do you hope to get out of vein treatment? _____

Family physician's name, address, and phone number: _____

Whom may we thank for referring you to our office? _____

By signing below I also consent to the taking of photographs for my medical record.

Patient's signature

Date



THE VEIN SPECIALISTS

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