Dermatology, Laser & Vein Specialists OF THE CAROLINAS

Girish S. Munavalli, MD, MHS
J. Blake Goslen, MD
Donna Beaty, PA-C

PATIENT MEDICAL HISTORY

Last Name: ____________________ First Name: ___________________ M.I. _______ D.O.B: ___________ Age: ____

Referring Physician or Source (ie. Magazine, etc):____

Surgical History (list all surgeries & dates): ____

Have you been hospitalized for any other reason: ____

List any other disease or condition we should know about: ____

Drug Allergies (please list and briefly describe reaction): ____

Do you have an allergy to Sulfa/sulfa drugs? □ Yes □ No   If yes, briefly describe reaction: ________________________________

Do you take any blood thinners, such as Coumadin, Plavix, or products containing aspirin (ex: Advil) on a regular basis? □ Yes □ No

Current Medications (including OTC medications & herbal supplements): ____

Are you on hormone therapy, estrogen, premarin, provera, birth control, etc. ? ____

Are you pregnant ? □ Yes □ No □ NA

Are you presently breast feeding? □ Yes □ No

How many times have you been pregnant? _______

Have you ever had a reaction to anesthetia? □ Yes □ No

Have you ever been tested for HIV/AIDS? □ Yes □ No

If yes, when? __________________ Result: □ Positive □ Negative

Do you have artificial joints? □ Yes □ No

Previous x-ray or radiation exposure/therapy? □ Yes □ No

Do you smoke? □ Yes □ No

Do you routinely take antibiotics for dental procedures? □ Yes □ No

HISTORY OF DISEASES:

Please check YES or NO to the following questions if you have now or have ever had the below diseases and/or conditions:

YES/NO ***VASCULAR***
- □ □ High Blood Pressure
- □ □ Chest Pain
- □ □ Heart Attack
- □ □ Heart Murmur
- □ □ Irregular Heartbeat
- □ □ Pacemaker/ICD
- □ □ Stroke
- □ □ Artificial Valve

YES/NO ***SYSTEMIC***
- □ □ Heart Disease
- □ □ Hepatitis/Jaundice
- □ □ Arthritis
- □ □ Bleeding Disorder
- □ □ Diabetes
- □ □ Thyroid
- □ □ Kidney
- □ □ Glaucoma
- □ □ Seizures/Blackouts
- □ □ Tuberculosis

YES/NO ***LUNGS***
- □ □ Emphysema
- □ □ Bronchitis
- □ □ Asthma
- □ □ Chronic Cough

YES/NO ***VEIN SYMPTOMS***
- □ □ Leg Pain/Aching
- □ □ Skin Changes
- □ □ Tired/Heavy Legs
- □ □ Leg Cramps
- □ □ Ulcer/Ulceration
- □ □ Swelling
- □ □ Itching/Burning
- □ □ Throbbing
- □ □ Blood Clots/DVT
- □ □ Leg Ulcer
- □ □ Phlebitis

PERSONAL AND FAMILY HISTORY OF SKIN CONDITIONS:

When you are exposed to sun, do you: □ Tan Always □ Tan/Burn □ Burn Always

Have you ever had skin cancer? □ Yes □ No

Has anyone in your family had skin cancer? □ Yes □ No

Do you have a history of any skin diseases? □ Yes □ No

If yes, please list: ____

If you answered YES to any of the VEIN SYMPTOMS or are here for a VEIN CONSULTATION (spider vein or varicose vein) please complete the remaining questions on the back of this page and sign the consent for treatment.

If you DID NOT answer YES to any of the VEIN SYMPTOMS you may skip the remaining questions on the back of this page while <u>still signing the consent for treatment</u>.

FAMILY HISTORY OF VARICOSE VEINS/SPIDER VEINS/LEG ULCERS/BLOOD CLOTS OR SWOLLEN LEGS.
(please circle which relatives have had any of these)
Mother Father Sister Brother Grandmother Grandfather Other _____________

PREVIOUS VEIN TREATMENT HISTORY:
☐ Vein Stripping ☐ Injections ☐ Laser ☐ Surgery ☐ Other _______________________

If so, when and where? ____

PERSONAL HISTORY OF VARICOSE VEINS OR SPIDER VEINS:

YES/NO
☐ ☐ Varicose Veins – how many years present? ____
☐ ☐ Related to Pregnancy?
☐ ☐ Related to Leg Injury?

YES/NO
☐ ☐ Symptoms are worse with prolonged standing/sitting?
☐ ☐ Symptoms are worse during menstrual cycle?
☐ ☐ Are you developing new veins?

☐ ☐ Do you elevate your legs to relieve discomfort?

If so, how many months/years? ____

☐ ☐ Is your discomfort/leg pain getting worse?

☐ ☐ Does your discomfort interfere with your daily living?

In what way? 1. _____________________________________ 2. ______________________________________

Work related interference: ____

☐ ☐ Do you take medication for leg pain (aspirin, advil, mortin, ibuprofen, other)?
If so, how long? ____

☐ ☐ Have you ever worn support hose prescribed by a doctor.
If so, how long? ___________________ What doctor? ____________________ Location: ___________________

☐ ☐ Did the hose provide relief to your symptoms?

☐ ☐ Have you ever had your veins evaluated before?
If so, when and where? ____

Did a physician refer you to our office for this vein consultation? If yes, please provide the following:

Doctor's name: _______________________ Address: ____________________________ Phone: ___________________

Physician Signature: _________________________________ / MA Initials: ____________ Date: _____________

CONSENT FOR TREATMENT

I hereby give my consent for medical examination and treatment.

I understand that no therapy is guaranteed. It is the policy of Dermatology, Laser & Vein Specialists of the Carolinas that no substantial procedures are performed upon me until I have an opportunity to discuss it with Dr. Goslen, Dr. Munavalli, or other healthcare professionals to my satisfaction.

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

I have provided this clinic a list of all medications (both prescribed and over the counter) that I am currently using.

I have reviewed the statement and agree to abide by the guidelines for my treatment.

Patient Signature: ____ Date: ______________________