



The Doctor's Offices of Sherman Hospital
915 Center Street, Suite 1000
Elgin, IL 60120

847.717.3265

Patient Name: _____

Patient Date of Birth: ____/____/____

Whom may we thank for referring you
to our office?

Who is your primary care physician? _____

May we have your e-mail address? _____

Patient Health History Form

Have you ever had any of the following:	No	Right	Left	Both	If so, when?
An injury to either of your legs that required an operation or casting?					
A deep vein thrombosis (D.V.T), also known as a blood clot in your leg?					
A Venous Stasis ulcer?					
Hemorrhage from a varicose vein?					
Sclerotherapy?					
Vein Stripping?					

Please answer the following very carefully, as it will help your insurance company decide if your vein problems are a covered benefit. In the last six months have you...

...tried support stocking(s) to relieve your vein problems without success? ____Yes ____No If yes, how long ago? _____ wks/mos/yrs	...had to take time off work because of your vein problems? ____Yes ____No
...had to take pain medicine because of your vein problem? ____Yes ____No	...had to limit your activities and lifestyle because of your vein problems? ____Yes ____No

Please indicate if you have any of the following conditions by circling Yes or No:

Diabetes	Yes No	Seizures	Yes No
Heart Disease	Yes No	Renal Failure	Yes No
Lung Disease	Yes No	Hepatitis	Yes No
Hypertension	Yes No	HIV Infection	Yes No
Arthritis	Yes No	Fainting	Yes No
Cancer	Yes No	Tobacco Use	Yes No

Please indicate by circling Yes or No if you currently or recently were on any of the following:

Coumadin	Yes No	Topical Skin Medications	Yes No
Plavix	Yes No	Antibiotics	Yes No
Daily Aspirin	Yes No	Steroids	Yes No

Please indicate your frequency with the following:

Tobacco	Never	Seldom	Moderate	Frequent	_____Packs/Day	Quit On: _____
Alcohol	Never	Seldom	Moderate	Frequent		
Exercise	Never	Seldom	Moderate	Frequent		

For Women Only: Please indicate Yes or No if you are...

Pregnant or think you might be?	Yes No	Taking Oral Contraceptives?	Yes No
Currently Nursing (Breast Feeding)?	Yes No	On Hormone Replacement Therapy?	Yes No
Do you think you will have more children?	Yes No	Do you anticipate starting Hormone Replacement Therapy soon?	Yes No

How many times have you gone through childbirth?

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Please list all medications that you are currently taking along with dosages and frequencies:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Are you allergic to anything? Yes No
If yes, please list any and all allergies:

Family History: Please indicate if any of the following conditions were present in your immediate family members:

Varicose Veins	Yes	No	Phlebitis	Yes	No
Venous Ulcers	Yes	No	History of Vein Surgery	Yes	No
Deep Vein Thrombosis	Yes	No	Blood Clots	Yes	No

Past Surgical History:

Have you ever had surgery? Yes No
If so, please fill in the following information:

Surgery	Approximate Date	Hospital/Location

Additional Medical History Not Mentioned Above:

Are you presently seeing another physician for anything NOT mentioned above? Yes No

If so, what is the doctor's name, and for what condition(s) is he or she treating you?

Have you ever been hospitalized for anything NOT mentioned above? Yes No

If so, for what, at which hospital, and when?

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Review of Symptoms: Do you currently have any of the following?
 If you check "Yes" for anything, please explain on the line below the checkbox.

Yes	No	Constitutional: (Fever, chills, recent unexplained loss of appetite or weight).
Yes	No	Eyes: (Any recent unexplained loss in visual activity, double vision, excessive tearing or crusting).
Yes	No	ENT: (Recent change in hearing ability, discharge, sore throat, dizziness, or ringing in the ears).
Yes	No	Cardiac: (Chest pain, shortness of breath, waking from sleep breathless or cardiac meds).
Yes	No	Respiratory: (Shortness of breath, productive cough, coughing up blood, or pain with breathing).
Yes	No	Gastrointestinal: (Change in bowel habits, black, red, or bloody stools, vomiting, or belly pain).
Yes	No	Genitourinary: (Incontinence, frequent, urgent, or painful urination, waking at night to urinate).
Yes	No	Musculoskeletal: (Change in walking ability or strength; painful joints).
Yes	No	Skin: (Problematic rashes or itching, changes in skin color, or sores that won't heal).
Yes	No	Neurological: (Unexpected, unexplained numbness, tingling, or loss of memory or movement).
Yes	No	Psychiatric: (Suicidal thoughts or hallucinations).
Yes	No	Migraines: (Please indicate frequency below).