

FRANKLIN CLINIC

CONFIDENTIAL MEDICAL HISTORY FORM

Patient's Name: _____ Date of Birth: _____

Check reason(s) for visit: Varicose Veins Spider Veins Hemorrhoids

1. When did you first notice the above problem(s)? _____

2. Have you seen another physician for this problem? Yes No
If yes, who? _____ When? _____
What treatment/testing was recommended? _____
Was the treatment/testing done? Yes No

3. List any significant illnesses for which you are currently under a physician's care:

4. Medication allergies? Penicillin: Yes No
Local Anesthetic: Yes No
Other: _____

5. List current medications, both prescription and non-prescription, including birth-control pills, aspirin, herbs, etc. and dosages: _____

6. List previous operations including cosmetic surgery: _____

7. Do you drink alcohol? Yes No If so, how much? _____
Do you smoke? Yes No If so, how much? _____

8. Are you pregnant or planning a pregnancy soon? Yes No

9. Do you have a pacemaker? Yes No

Review of Medical History:

- HIV Yes No Details: _____
Hepatitis or other Liver Disease Yes No Details: _____
Bleeding disorder Yes No Details: _____
Benign or malignant tumor..... Yes No Details: _____
Diabetes Yes No Details: _____
High Blood Pressure..... Yes No Details: _____
Heart Disease or Stroke Yes No Details: _____
Kidney disease..... Yes No Details: _____

Patient's Name: _____ Date of Birth: _____

Review of Medical History Continued:

- Asthma..... Yes No Details: _____
- Inflammation of a vein (phlebitis)..... Yes No Details: _____
- Blood clot in the legs..... Yes No Details: _____
- Blood clot in the lungs..... Yes No Details: _____
- Stomach or Intestinal Ulcers Yes No Details: _____
- Crohn's Disease Yes No Details: _____
- Rectal Bleeding Yes No Details: _____
- Black Tarry Stools Yes No Details: _____
- Constipation or Diarrhea Yes No Details: _____
- Change in Bowel Habits..... Yes No Details: _____
- Family History of Colon Cancer Yes No Details: _____
- Neurological Disease or Epilepsy Yes No Details: _____
- Depression or Emotional Problems Yes No Details: _____
- Other (please specify): _____

Tests Performed:

- Ultrasound of Veins Never Yes Date: _____ Results: _____
- Rectal Exam Never Yes Date: _____ Results: _____
- Stool Occult Blood Never Yes Date: _____ Results: _____
- Sigmoidoscopy Never Yes Date: _____ Results: _____
- Colonoscopy Never Yes Date: _____ Results: _____

Review of Symptoms:

Legs (Varicose or Spider Veins):

- Aching Yes No
- Itching..... Yes No
- Numbness or Tingling Yes No
- Fullness or Pressure..... Yes No
- Swelling..... Yes No
- Leg Restlessness..... Yes No
- Muscle Cramping Yes No

Rectum (Hemorrhoids):

- Burning..... Yes No
- Itching..... Yes No
- Bleeding Yes No
- Protrusions..... Yes No
- Constipation Yes No

This information is true and correct to the best of my knowledge.

Patient's Signature

Date