



HEALTH SUMMARY

PALMETTO VEIN AND SURGERY CENTER
a division of S.C. Internal Medicine and Rehabilitation, LLC

1 Wellness Boulevard ❖ Suite 103 ❖ Irmo, South Carolina ❖ 803-407-8346 ❖ Fax 803-732-2624

Patient's Name (PLEASE PRINT): \_\_\_\_\_

Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

REVIEW OF SYSTEMS: Are you CURRENTLY experiencing any of the following? Please check ALL boxes that apply.

CONSTITUTIONAL

- Good heath lately
Recent weight gain
Recent weight loss
Fever
Fatigue
Headaches

GENITOURINARY

- Frequent urination
Burning or painful urination
Blood in urine
Change in force of stream
Incontinence or dribbling
Kidney stones
Sexual difficulty

CARDIO/VASCULAR

- Heart trouble
Chest pain
Palpitations
Varicose veins

ALLERGIES

- Runny/Stuffy nose
Watery eyes
Itchy nose, eyes and roof of mouth
Sneezing
Pressure in the nose and cheeks
Ear fullness and popping
Dark circles under the eyes
Hives

SKIN

- Rash or itching
Change in skin color
Change in hair or nails

NEUROLOGICAL

- Frequent or recurrent headaches
Light headed or dizziness
Convulsions/seizures
Numbness or tingling
Extremity Weakness

ENDOCRINE

- Thyroid problems
Diabetes
Excessive thirst/urination
Heat or cold intolerance

EAR, NOSE & THROAT

- Hearing loss
Ringing in ears
Earaches
Sinus problems
Nose bleeds
Sore throat

SLEEP

- Snoring
Stop breathing/ gasp for air at night
Dry mouth/ Sore throat
Wake up with headaches
Often tired during the day/ while driving
Often fall asleep while reading/ watching TV

EYES

- Eye disease or injury
Wear glasses/contacts
Glaucoma
Blurred or double vision

HEMATOLOGIC / LYMPHATIC

- Slow to heal after cuts
Easily bruise or bleed
Anemia
Past blood transfusion
Enlarged glands

RESPIRATORY

- Frequent coughing
Coughing up blood
Shortness of breath
Asthma/Wheezing

GASTROINTESTINAL

- Loss of appetite
Change in bowel movements
Blood in stool
Stomach pain
Hemorrhoids
Nausea/Vomiting
Heartburn

PSYCHIATRIC

- Memory loss
Nervousness
Depression

MUSCULOSKELETAL

- Joint pain
Joint stiffness or swelling
Muscle pain/cramps
Back pain

CURRENT HEALTH HABITS:

How often do you exercise:
Never Rarely Daily

Smoking:
- Have you ever smoked? Yes No
- Number of Years:
- How many packs currently smoked daily?
- Use of smokeless tobacco? Yes No

## HEALTH SUMMARY

**DRUG ALLERGIES:** Please list ALL medications you are allergic to.

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**CURRENT MEDICATIONS:** Please list ALL meds you are currently taking. Include dosage and how often you take each med.

MEDICATION (including over-the-counter)	DOSAGE	HOW OFTEN DO YOU TAKE?

**PREVIOUS MEDICAL ILLNESSES:** Please check any illnesses you have had in the past.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Anemia / Low Blood<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding from Bowels<br><input type="checkbox"/> Bleeding Problems, Type: _____<br><input type="checkbox"/> Blood Clot in Leg<br><input type="checkbox"/> Blood Clot in Lung<br><input type="checkbox"/> Blood Transfusion<br><input type="checkbox"/> Cancer, Type: _____<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes / High Blood Sugar | <input type="checkbox"/> Emphysema / Chronic Bronchitis<br><input type="checkbox"/> Epilepsy / Seizures<br><input type="checkbox"/> Gallstones<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Irregular Heart Beat<br><input type="checkbox"/> Kidney Disease, Type: _____<br><input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Liver Disease, Type: _____<br><input type="checkbox"/> Prostate Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Skin Disease, Type: _____<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers in Bowels / Stomach<br><input type="checkbox"/> Varicose Veins or Spider Veins<br><input type="checkbox"/> Other: _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**VASCULAR HISTORY:** Please check any methods you have used to relieve leg discomfort.

- |                                                                                                                                                                                 |                                                                                                                                                           |                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Aspirin<br><input type="checkbox"/> Cold packs<br><input type="checkbox"/> Exercise/Walking<br><input type="checkbox"/> Flexion/extension of your feet | <input type="checkbox"/> Ibuprofen<br><input type="checkbox"/> Leg elevation<br><input type="checkbox"/> Support hose<br><input type="checkbox"/> Tylenol | <input type="checkbox"/> Warm soaks<br><input type="checkbox"/> Wraps<br><input type="checkbox"/> Other Method: _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|

Are you on your feet for long periods?  Yes  No      In what capacity? \_\_\_\_\_

Walking/exercise:  relieves your discomfort **or**  makes it worse

Have you been treated for your veins before?  Yes  No

If yes, please check the following that apply:

- |                                                                                                                                                                                 |                                                                                                                                                                                                       |                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Injections<br><input type="checkbox"/> Stripping<br><input type="checkbox"/> Ambulatory Phlebectomy<br><input type="checkbox"/> Radiofrequency Closure | <input type="checkbox"/> Laser Catheter Ablation<br><input type="checkbox"/> Laser for Spider Veins<br><input type="checkbox"/> Ultrasound-Guided Injections<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> By Whom? _____<br>_____<br><input type="checkbox"/> When?<br>_____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|

## HEALTH SUMMARY

**Females ONLY:** Please write N/A on the lines that DO NOT apply to you, or leave blank.

Are you pregnant or planning to be pregnant soon?  Yes  No      Are you currently breast feeding?  Yes  No

Number of Pregnancies: \_\_\_\_\_      Number of Miscarriages: \_\_\_\_\_      Number of Deliveries: \_\_\_\_\_

Current form of Birth Control: \_\_\_\_\_

### SURGERY HISTORY:

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy of:	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery <input type="checkbox"/> R <input type="checkbox"/> L	
Gallbladder	
Broken Bone Repair	

SURGERY	DATE
Joint Replacement	
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Hysterectomy	
Other: _____	

### CURRENT SPECIALISTS:

SPECIALTY	NAME	LOCATION	PHONE #

**FAMILY HISTORY:** Check beside any disease that has affected your parents, brothers, and/or sisters.

- |                                              |                                                      |                                                |
|----------------------------------------------|------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Cancer /Type:         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Alcohol Abuse         |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Epilepsy / Seizures         | <input type="checkbox"/> Anxiety or Depression |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bleeding Problems           | <input type="checkbox"/> Glaucoma              |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Sickle Cell Anemia          | <input type="checkbox"/> Other:                |
| <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Diabetes / High Blood Sugar |                                                |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Thyroid Problems            |                                                |

### SOCIAL HISTORY:

❖ **Primary language if not English:** \_\_\_\_\_

❖ **Current Employment:**  Full-time  Part-time  Not working  Retired  Student

❖ **Religion:** describe any ethnic, religious or cultural beliefs you have that may/will influence your treatment.

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