LONG ISLAND
VEIN CARE & SURGERY PLLC.

Medical History

Patient Name: _____ Date: _____
Height: _____ Weight: _____ Weight loss/gain in past year: _____lbs (circle one)
Most recent physical exam: _____ Name of Physician seen: _____
Most recent electrocardiogram: _____ Chest X-ray: _____

Previous Surgery

Operation Year Anesthesia (yes or no)

_____
_____
_____
_____

Medication Allergies: _____

Medications

Name Dosage Medical Issue Start Date

_____
_____
_____
_____
_____
_____
_____

Do you have any medical issues or take any medications like blood-thinners which increase your risk of bleeding? Yes / No

Condition/Medication w/ Dosage: _____
Diagnosis/Start Date: _____

Do you have a history of blood clots? Yes / No