

# Medical History

Client Reference No: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

GP's Name: \_\_\_\_\_  
GP's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Day Tel: \_\_\_\_\_ Eve Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_  
D.O.B: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

## Medical History

Are you, or might you be pregnant?  Are you currently seeing your GP for any medical condition?   
Are you breast feeding?

Do you suffer from, or have you in the last five years been treated for:

Diabetes <input type="checkbox"/>	Ankle swelling <input type="checkbox"/>	Kidney disease <input type="checkbox"/>
High blood pressure <input type="checkbox"/>	Cancer <input type="checkbox"/>	Arthritis <input type="checkbox"/>
Liver disease <input type="checkbox"/>	Cellulitis <input type="checkbox"/>	Blood disorders <input type="checkbox"/>
Asthma <input type="checkbox"/>	Auto immune disease <input type="checkbox"/>	Chronic skin condition <input type="checkbox"/>

Have you ever suffered from:

Phlebitis  Deep vein thrombosis  Pulmonary embolus  Heart disease  Stroke  Leg ulceration

Do you have any allergies?  Have you ever had an anaphylactic reaction?  Are you fully mobile?

Are you taking any of the following medication?

Steroids  Antibiotics  Warfarin  Aspirin  HRT/oral contraceptives

### Initial Assesment:

#### Left leg

Varicose veins on physical examination:

#### Veins to be treated:

Matting:

Telangectasia:

Threads:

Spider:

Reticular:

#### Skin:

Warm:

Discolouration:

Normal texture:

### Initial Assesment:

#### Right leg

Varicose veins on physical examination:

#### Veins to be treated:

Matting:

Telangectasia:

Threads:

Spider:

Reticular:

#### Skin:

Warm:

Discolouration:

Normal texture:

Notes: