940 Maritime Drive, Suite 4, Manitowoc, WI
P: (920) 686-7900 FAX: (920) 686-7984
Premier Surgical of Wisconsin, SC

Welcome to the Wisconsin Vein Center

REASON FOR YOUR EVALUATION TODAY
In your own words, please describe what brings you to us

FAMILY DOCTOR	CONSULT FROM
Name: Address: Phone:	Name: Address: Phone:

PHARMACY NAME / LOCATION	PHARMACY PHONE #

ALLERGIES ☐ None Check here if none, otherwise list below

MEDICATION / AGENT	REACTION

Latex Allergy ☐ YES ☐ NO Allergy or sensitivity to metals (nickel, gold, etc) ☐ YES ☐ NO

MEDICATIONS (include herbal remedies) ☐ None Check here if none, otherwise list below

MEDICATION NAME	DOSE & TIMES A DAY	MEDICATION NAME	DOSE & TIMES A DAY

Are you currently taking Solodyn, Minocycline, or Minocin ? ☐ Yes ☐ No

Are you currently taking a blood thinner? (Warfarin, Coumadin, Aspirin, Plavix, Pradaxa, Xeralto) ☐ Yes ☐ No

PERSONAL SURGICAL HISTORY ☐ None Check here if none, otherwise list below

DATE	TYPE OF SURGERY	DATE	TYPE OF SURGERY

Above information reviewed, and modified as indicated, by: _____

Kimberly A. Ridl, MD

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PAST MEDICAL HISTORY

Please check yes to any conditions that you are currently treated for or have been treated for in the past

	√	Comments		√	Comments
High blood pressure			Stroke/TIA		
Diabetes			Kidney disease		
Chest pain, heart attack			Irregular heart rhythm		
Heart Disease			Artificial heart valve		
Hepatitis			Liver disease		
Asthma, Emphysema			High Cholesterol		
Cancer			Bleeding/clotting disorder		
Under/over active thyroid			Melanoma		
Pacemaker/Defibrillator			Internal electrical device		
Seizures or epilepsy			Migraine headaches		

Other:

	PERSONAL AND SOCIAL HISTORY	YES	NO	COMMENTS
1	Have you ever received a blood transfusion?			When?
2	Do you use or have you used recreational drugs?			What? How often?
3	Have you received a tattoo?			
4	Have you ever been poked by a dirty needle?			When?
5	Any other risks for HIV or Hepatitis?			
6	Do you drink alcohol?			How much?
7	Do you currently smoke?			How much? # of years?
8	Have you ever smoked?			When did you quit?
9	Do you have children?			How many?
10	Do you exercise regularly?			How often?
11	What type of work do you do?			
12	Marital Status: (circle one) Single Married Divorced Widowed			

FAMILY HISTORY

Include any blood related immediate family members (parents, grandparents, siblings children, aunts, & uncles)

	YES	NO	?	RELATIONSHIP
Varicose veins, spider veins, open sores on legs				
Diabetes				
Anesthesia problems				
Bleeding or clotting disorders				
Cancer				
Other:				

PARENTS:

Mother: ☐ Living, Current age_____ ☐ Deceased, Age_____ Cause_____

Father: ☐ Living, Current age_____ ☐ Deceased, Age_____ Cause_____

OTHER PERTINENT FAMILY HISTORY or any other medical information you feel we should know about:

Above information reviewed, and modified as indicated, by: _____

Kimberly A. Ridl, MD