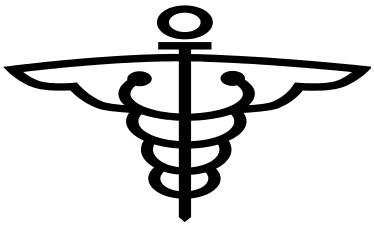

Total Vein Treatment Centers
VENOUS HEALTH HISTORY

NAME:_____ **DATE:**_____

HEIGHT_____ **WEIGHT**_____

ALCOHOL AND TABACCO

	Present Use	Amount
Caffeine		
Alcohol		
Tobacco		

Previous Surgeries:

_____
_____
_____
_____

Allergies:

Medication	Type of reaction

Are you taking any Medications?

Name of Medicine	Dosage and frequency	Reason

Pharmacy Contact Number

Name:_____

Address:_____

Fax#/Phone#_____

EMERGENCY CONTACT

NAME:_____ **PHONE:**_____

NAME:_____ **PHONE:**_____

Signature:_____ **Date:**_____