BUCKS COUNTY CENTER FOR VEIN MEDICINE

NAME_____DATE_____

1. **DO YOU HAVE ANY KNOWN ALLERGIES? IF SO, PLEASE LIST.**

2. **HAVE YOU EVER FELT LIGHTHEADED OR FAINTED WHILE RECEIVING AN INJECTION OR WHILE HAVING BLOOD DRAWN?**

3. **DO YOU HAVE SENSITIVE SKIN OR ARE YOU PRONE TO DEVELOP SKIN RASHES?**

4. **DO YOU HAVE A HISTORY OF ASTHMA?**

5. **ARE YOU PREGNANT? DO YOU PLAN TO BECOME PREGNANT?**

6. **IF YOU ARE A NEW MOTHER, ARE YOU NURSING YOUR BABY?**

IMPORTANT
IMMEDIATELY INFORM THE DOCTOR OF PHYSICIAN ASSISTANT SHOULD YOU BECOME LIGHTHEADED, DIZZY, OR NAUSEATED DURING YOUR VISIT OR TREATMENT SO THAT WE CAN PREVENT ANY FURHTER PROBLEMS.