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PATIENT NAME: _____ DATE OF BIRTH: _____

HOME PHONE: _____ REFERRING PHYSCIAN_____

VEIN AND VASCULAR HEALTH HISTORY

REASON FOR VISIT: Please list when condition started, is it better or worse now.

_____
_____
_____
_____
_____

CURRENT MEDS: Please list current meds, frequency, and dosage

_____
_____
_____
_____

Varicose Veins/Spider Veins: Please circle all that apply

1. Do you experience any of the following?
   a. Aching pain in your legs?_____ YES NO
   b. Heaviness_____ YES NO
   c. Tiredness / fatigue_____ YES NO
   d. Itching / burning _____YES NO
   e. Swollen ankles _____ YES NO
   f. Leg cramps _____YES NO
   g. Restless legs _____ YES NO
   h. Throbbing _____ YES NO
   i. Other _____
2. Have your veins gotten worse in the recent months? ____ YES NO
3. Do you elevate your legs to relieve discomfort? _____ YES NO
4. Do you, or have you used any type of support / compression hose? _____YES NO
5. Do they provide relief? _____ YES NO

6. Are you taking any pain medicine? _____ YES NO
   a. What type and how often? _____
   _____

7. Are you taking any iron supplements or vitamins with iron? YES NO

8. Have you ever had your veins evaluated before? _____ YES NO
   If so, when and where? _____

9. Have you ever had a superficial vein or varicose vein blood clot, phlebitis? ____ YES NO

10. Have you ever had a deep vein thrombosis? _____ YES NO

11. Have you ever had vein stripping surgery? _____ YES NO
    If yes, when and which leg? _____

12. Have you ever had vein injections? _____ YES NO
    If yes, which leg and where on the leg? _____
    _____

Past Medical History

Please answer below by circling yes or no.

High Blood Pressure	YES	NO	Diabetes	YES	NO	Neuropathy	YES	NO
Heart Problems	YES	NO	Heart Attack/MI	YES	NO	Heart Failure/CHF	YES	NO
Stroke/CVA/TIA	YES	NO	High Cholesterol	YES	NO	Kidney Disease	YES	NO
Thyroid Disease	YES	NO	Emphysema/COPD	YES	NO	Cancer	YES	NO
Bleeding? Ulcer?	YES	NO	Aneurysm	YES	NO	DVT/Blood Clot	YES	NO
Seizures	YES	NO	Collapsed lung	YES	NO			

Family History

Has anyone in your family ever had:

Cancer	Father	Mother	Brother / Sister
Diabetes	Father	Mother	Brother / Sister
Hypertension	Father	Mother	Brother / Sister
Heart Problems	Father	Mother	Brother / Sister
Aneurysms	Father	Mother	Brother / Sister
Stroke	Father	Mother	Brother / Sister
Varicose Veins	Father	Mother	Brother / Sister

Social History:

Alcohol YES NO If yes, how much? _____

Tobacco Use YES NO If yes, how much? _____

If you stopped, when? _____

PAST SURGICAL HISTORY

Please list all surgeries and when: _____

_____

_____

_____

_____

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY

Constitutional: fever, chills, weight loss / gain – lbs _____
Skin: ulcers, rash, itching, cellulites, melanoma, basal cell cancer, squamous cell cancer
Eyes: temporary loss of vision in one eye, blurred vision, cataracts, glasses
ENT: dentures, ear problems, hearing aid, nose bleeds, congestion, swallowing problems
Cardiac: chest pain, angina, chest pain with exertion, palpitations, leg swelling, ankle swelling
Respiratory: short of breath, wheezing, shortness of breath when lying flat
GI: nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stools
GU: frequency, urgency, burning when urinate, prostate problems, kidney disease
Musculoskeletal: pain legs / calf with walking, sciatica, back pain, back disc disease, joint pain
Neurologic: dizzy, lightheaded, weak or numb one side – arm / leg / face, headache, pass out
Psych: depression, anxiety, psychosis, rehab for drug or alcohol abuse
Endocrine: excessive thirst or urination, thyroid disease
Heme / Immune: HIV / AIDS, Hepatitis A, B, C, Allergies, easy bruising, clotting disorder

For Clinic Use Only:

NOTES: _____

_____

_____

_____

Circle all that apply:

Reviewed Venous history, Physical examination of the affected leg(s), Duplex or Doppler Scan order of the affected leg(s), Graduated, elasticized compression stockings (30-40 mmHg), Prescription for graduated, elasticized compression stockings given to patient, Standing photos taken of leg(s), Clinical notes received from referring physician, Instructions given on medication dosage, Instruction given on daily leg elevation, Instruction given for mild exercise, Instruction given for weight reduction.

Doctor's Signature _____ Date _____