RAFFI K. KRIKORIAN, M.D., FACC, RVT
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CONFIDENTIAL HEALTH & VASCULAR HISTORY

PATIENT INFORMATION

Patient Name: _____ Date: _____
Age: ____ Sex: ____ DOB: _____ Years with varicose/spider veins? _____

HOW DID YOU HEAR ABOUT US?

Referring Doctor? _____
Newspaper? _____
Phone book? _____
Web site? _____
Other? _____

SYMPTOMS? *Circle R for right leg, L for left leg, B for both legs*

Please check if you have:

__ Red spider veins R L B
__ Skin discoloration below knee R L B
__ Purple veins R L B
__ Ankle/leg sores/wounds R L B
__ Varicose veins R L B
__ Heaviness R L B
__ Itching/burning R L B
__ Restless Legs R L B
__ Abdominal veins R L B
__ Bulging veins R L B
__ Diagnosis of vein disease R L B
__ Flat bluish-green veins R L B
__ Swelling R L B
__ Tiredness/fatigue R L B
__ Leg cramps R L B
__ Throbbing R L B

MEDICAL HISTORY

Is there a family history of varicose or spider veins in your family?
Describe which: __ Mother _____ __ Father _____
__ Siblings _____ __ Aunt _____
__ Uncle _____ __ Child _____
__ Grandparents _____

Is there a history in your **FAMILY** of deep vein thrombosis, stroke, or clotting disorders?
__ Yes __ No
If yes, Who/what? _____

Do **YOU** Have a History of?

__ Anemia
__ Bleeding disorders
__ Crohn's Disease, IBS
__ Easy bruising
__ Hepatitis
__ Leg ulcers
__ Migraine headaches
__ Rupture of a vein
__ Ankle Skin Changes
__ Chest pain/pressure
__ Deep Vein Thrombosis
__ HIV
__ Hypertension
__ Liver disease
__ Mitral Valve Prolapse
__ Phlebitis
__ Atherosclerosis
__ Diabetes
__ Edema/leg swelling
__ Heart disease
__ Kidney disease
__ Lupus
__ Pulmonary Embolus
__ Trauma to your legs

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Patient Name _____

Have you ever been tested for or found positive for a PFO (Patent Foramen Ovale) or ASD (Atrial Septal Defect)? __ Yes __ No
Are you allergic to any medications or tape? __Yes __ No. If yes, Please list all:

_____

Are you being treated for any illnesses or conditions? Please explain:

_____

Please list all medications that you take (prescriptions, over the counter, herbal and vitamin):
_____ Women only:
Are you pregnant or planning to be soon? ____Currently breast feeding? ____ Do you have discomfort around your menses? _____

VASCULAR HISTORY

Please check any methods you have used to relieve your leg discomfort:

__ No discomfort
__ Flexion/extension of your feet
__ Walking
__ Wraps (ace, etc)
__ Cold packs
__ Tylenol
__ Other methods: _____
__ Exercise
__ Leg elevation
__ Support Hose
__ Warm soaks
__ Pain meds =_____
__ Ibuprofen

What was the **earliest** date you started pain medications for leg problems, and what was the outcome? _____
What was the **earliest** date you wore medical support hose for your leg problems?
_____ (**some insurance plans require that compression hose be worn for a few months prior to request for treatment).**
How have your daily activities been affected or limited by your leg problems?

_____

Are you on your feet for long periods? _____ in what capacity? _____
Does walking/exercise relieve your discomfort or make it worse? _____
Have you been **treated** for your veins before? ____ By whom? _____When? _____

What method**/which** leg **R**ight**, L**eft**, B**oth**:**

__ Cosmetic injections/sclerotherapy R L B
__ Stripping R L B
__ Ambulatory Phlebectomy R L B
__ Ligation R L B
__ Ultra Sound Guided Injections R L B
__ Radio Frequency Closure R L B
__ Laser Catheter Ablation R L B
__ Laser for Spider Vein R L B
__ Other: _____
What have your results been? _____
What about your legs would you now most like to correct? _____

Patient signature: _____**Date**_____

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Patient Name: _____

For Office Use Only

Check/Circle all that apply:

__ **Graduated stockings** to be ordered/mailed to pt.

__ Knee High __ Thigh High __ Panty Hose
__ 20-30mmHg __ 30-40mmHg

Measurements:

Ankle = _____ Inches **Calf** = _____ Inches **Thigh**= _____ Inches **Ht**=_____ Inches

_____ _____
Type/Company/Size/Hose Provided. Date done by signature

__ **Pictures** to be taken _____ _____
Date done by signature

__ **Schedule Procedure:**

__ Radio Frequency Thermal Ablation
__ Ultra Sound Guided Sclerotherapy
__ Visual Sclerotherapy
__ Ambulatory Phlebectomy

__ Instructions on varicose veins (handouts given____)

__ Instructions on sclerotherapy (handouts given____)

__ Instructions on Radio Frequency Thermal Ablation

__ Other: _____