

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:

- | | |
|--|--|
| <input type="checkbox"/> Red spider veins R L B | <input type="checkbox"/> Abdominal veins R L B |
| <input type="checkbox"/> Skin discoloration below knee R L B | <input type="checkbox"/> Bulging veins R L B |
| <input type="checkbox"/> Purple veins R L B | <input type="checkbox"/> Diagnosis of vein disease R L B |
| <input type="checkbox"/> Ankle/leg sores/wounds R L B | <input type="checkbox"/> Flat bluish-green veins R L B |
| <input type="checkbox"/> Varicose veins R L B | <input type="checkbox"/> Swelling R L B |
| <input type="checkbox"/> Heaviness R L B | <input type="checkbox"/> Tiredness/fatigue R L B |
| <input type="checkbox"/> Itching/burning R L B | <input type="checkbox"/> Leg cramps R L B |
| <input type="checkbox"/> Restless Legs R L B | <input type="checkbox"/> 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?

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



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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 Exercise
- Flexion/extension of your feet Leg elevation
- Walking Support Hose
- Wraps (ace, etc) Warm soaks
- Cold packs Pain meds = _____
- Tylenol Ibuprofen
- Other methods: _____

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 Right, Left, Both:

- Cosmetic injections/sclerotherapy R L B Ultra Sound Guided Injections R L B
- Stripping R L B Radio Frequency Closure R L B
- Ambulatory Phlebectomy R L B Laser Catheter Ablation R L B
- Ligation 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 _____



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
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<input type="checkbox"/> Pictures to be taken	Date done	by signature
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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: _____