Patient History

Patient Information

Last Name: _____ First Name: _____Date of Birth: _____

Primary Doctor: _____ Today's Date: _____

Vein Questionnaire and History

We will use the information you provide to help us make the most appropriate recommendations for your care. Your insurance carrier may also use this information to judge whether your problems are medically necessary, and to determine if you have already attempted to help your problems with conservative measures such as exercise, periodic elevation, avoidance of prolonged standing, and wearing compression socks.

Do you currently have, or ever had, any of these symptoms in your legs? (check all that apply)

☐ Varicose Veins	☐ Leg Cramping	☐ Leg Fatigue	☐ Leg Heaviness	☐ Leg Itching
☐ Pelvic Pain	☐ Leg Aching	☐ Leg Throbbing	☐ Leg Night Cramps	☐ Leg Pain
☐ Restless Legs	☐ Leg Swelling	☐ Skin Discoloration	☐ Open Leg Wounds	☐ Spider Veins
☐ Leg Burning	☐ Bleeding from Veins	☐ Deep Vein Clot	☐ Superficial Clot	☐ Other: _____

Which leg gives you more problems? ☐ Right ☐ Left ☐ Same in Both Legs

Do you use pain medication for leg issues? ☐ Yes ☐ No. If yes, what kind of medication? _____

Do you try to elevate your legs? ☐ Yes ☐ No

Do you avoid prolonged standing? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you avoid prolonged sitting? ☐ Yes ☐ No

Are you on a weight loss/management routine? ☐ Yes ☐ No. If yes, how much weight lost? _____

How many weeks, months, or years, have you lived with leg problems? _____

Have your legs worsened over time? ☐ Yes ☐ No

Have you ever worn medical grade 20-30mmHg compression stockings/socks? ☐ Yes ☐ No

If yes, were these socks prescribed by a medical practitioner? ☐ Yes ☐ No. If yes, who? _____

If yes, how many weeks, months, or years have you worn them ***in total***? _____

Specifically, how do your legs limit your daily life (check all that apply):

☐ Waking up at night	☐ Hard to fall asleep	☐ Limits performance at work	☐ Limits how long I can stand
☐ Limits Exercise	☐ Limits how long I can walk	☐ Limits how long I can sit	☐ Affects my daily chores

☐ Other: _____

Have you been treated for your leg veins before? ☐ Yes ☐ No. If yes, by whom? _____When? _____

If yes, by which of the following:

☐ Cosmetic Injections	☐ Ultrasound Guided Injections	☐ Radio Frequency Closure	☐ Ligation
☐ Laser Catheter Ablation	☐ Laser spider veins	☐ Vein Stripping	☐ I don't know
☐ Ambulatory Phlebectomy	☐ Other: _____		

What would you like to correct the most about your legs? _____

Have you been or are you currently on a blood thinners? ☐ Yes ☐ No If yes, for how long? _____

Do you have a family history of Varicose Veins/Spider Veins/ Deep Vein Clot? ☐ Yes ☐ No. If yes, ☐ Mom ☐ Dad ☐ Grandparent

Please list your current medication(s): _____

_____

Please list the medications you are allergic to and your reaction to each medication: _____

_____

Please list any surgeries that you have had:_____

Have you had any of the following medical illnesses? (check all that apply)

☐ COPD	☐ Blood Transfusions	☐ High Cholesterol	☐ HIV or AIDS	☐ Clot in lungs (PE)	☐ Herpes
☐ Stroke	☐ Arthritis	☐ Clot in Legs (DVT)	☐ Kidney Problems	☐ Asthma	☐ Gout
☐ Hole in Heart	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Depression	☐ Liver Disease	☐ Anemia
☐ Pacemaker	☐ Dialysis	☐ Hepatitis B	☐ Diabetes	☐ Migraines	☐ Lupus
☐ Hepatitis C	☐ Tuberculosis	☐ Heart Attack (MI)	☐ Thyroid Problems	☐ Multiple Sclerosis	☐ Goiter
☐ Epilepsy	☐ Prostate Problems	☐ Bleeding Disorder	☐ Miscarriage	☐ Heart Disease	
☐ Cancer, what kind: _____		☐ Ulcers, what kind: _____		☐ Other: _____	

Social History

Occupation: _____ Employer: _____

Average number of alcoholic beverages per week: ☐ None ☐ 1-5 ☐ 6-10 ☐ 10+

Do your daily activities include prolonged periods of sitting and standing? ☐ Yes ☐ No

Have you ever, or do you now use tobacco? ☐ Yes ☐ No. If yes, please explain: _____

Females Only

Are you pregnant? ☐ Yes ☐ No

Are you planning on becoming pregnant? ☐ Yes ☐ No

Are you breast feeding? ☐ Yes ☐ No

Do you have discomfort around your mensural cycle? ☐ Yes ☐ No

Number of Children _____ Number of miscarriages: ____

Office Use Only

Blood Pressure: _____ Heart Rate: _____Weight: _____Height: _____

ANKLE Dimensions: R_____ **L** _____ **CALF Dimensions R**_____ **L** _____

RIGHT LEG

Varicose Veins	T	K	C	A
Spider Veins	T	K	C	A
Edema	M	1+	2+	3+
Pitting	M	1+	2+	3+
Ulcer	A	C	K	T
Lipodermatosclerosis	A	C		
Hemosiderosis	A	C		
Atrophie Blanche	C	T		
Induration	C	T		
Inflammation	A	C	T	

LEFT LEG

Varicose Veins	T	K	C	A
Spider Veins	T	K	C	A
Edema	M	1+	2+	3+
Pitting	M	1+	2+	3+
Ulcer	A	C	K	T
Lipodermatosclerosis	A	C		
Hemosiderosis	A	C		
Atrophie Blanche	C	T		
Induration	C	T		
Inflammation	A	C	T	