VEINTEC VARICOSE VEIN CLINICS

Patient Name: ____ Date: ___________________

Referred By: Physician's Name ☐ _______________________, Friend ☐_______________________, Advertisement ____________________, Other: _____________________

Primary Care Physician: __________________________

HEALTH MAINTENANCE
What would you most like to correct about your legs? ____
____

PROBLEM LIST / PAST MEDICAL

- ☐ None
- ☐ Anemia
- ☐ Atherosclerosis
- ☐ Bleeding / Blood Disorder
- ☐ Deep Vein Thrombosis / Clot
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hypertension (high blood pressure)
- ☐ Kidney Disease
- ☐ Leg Ulcers
- ☐ Liver Disease
- ☐ Hyperthyroidism
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Pulmonary Embolus
- ☐ Rupture of a Vein
- ☐ Stroke
- ☐ Superficial thrombophlebitis
- ☐ Osteoarthritis

Do you have any other current illnesses? ☐ Yes ☐ No If yes, please describe:
____

PAST SURGICAL
(Check those that apply & elaborate)

	Date & Type of Surgery
☐ Abdominal	______________________________
☐ Heart	______________________________
☐ Head and Neck	______________________________
☐ OB/GYN	______________________________
☐ Breast	______________________________
☐ Orthopedic	______________________________
☐ Other	______________________________

Previous Vein Treatment:

Treatment	Leg	Date	Provider
☐ Stab Phlebectomy	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Varicose vein injections	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Endovenous laser ablation	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Ligation and / or stripping	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Radio-frequency ablation	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Spider vein injections	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________
☐ Spider vein laser therapy	Leg: ☐ Rt ☐ Lt ☐ Both	Date: _________	Provider:__________

VEINTEC VARICOSE VEIN CLINICS: History & Physical Patient Name: ____________________

Patient Height: ___ ft. ___ in. Patient Weight: ________

ALLERGIES

Allergy to **medications** or other substances? ☐ Yes ☐ No If yes, please list: _______________________

____

MEDICATION

Please list any **current medications, vitamins, or herbal supplements** that you are taking:

Drug ___________dosage (mg)_____frequency______ | Drug __________dosage (mg)_______frequency______

Drug ___________dosage (mg)_____frequency______ | Drug __________dosage (mg)_______frequency______

Drug ___________dosage (mg)_____frequency______ | Drug __________dosage (mg)_______frequency______

Drug ___________dosage (mg)_____frequency______ | Drug __________dosage (mg)_______frequency______

Drug ___________dosage (mg)_____frequency______ | Drug __________dosage (mg)_______frequency______

Vitamins / Minerals ____

____

____

Pharmacy Name & Address: _________________________________ Phone #: ______________________

FAMILY (Please note family member that has diagnosis—see reference list to right)

Varicose Veins _________________________

Deep Vein Thrombosis _________________________

Stroke _________________________

Blood Clotting Problem _________________________

Please designate relative by: None, Mother, Father, Daughter, Son, Sister, Brother, Maternal Grandfather or Grandmother, Paternal Grandmother or Grandfather, Maternal Aunt or Uncle Paternal Aunt or Uncle, Maternal or Paternal Great Aunt or Great Uncle

SOCIAL

Occupation: ____________________________

On feet for long periods of time? ☐ Yes ☐ No If yes, in what capacity: __________________________

Walking: ☐ Increases Discomfort
☐ Decreases Discomfort

Tobacco Use:
- ☐ Smoker
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Current status unknown
- ☐ Unknown if ever smoked

Alcohol Use:
- ☐ Never
- ☐ Current
- ☐ Former

Alcohol drinks per day: ________

VEINTEC VARICOSE VEIN CLINICS: History & Physical **Patient Name: ____________________**

PREGNANCY / BIRTH

Are you now, or are you planning to be pregnant? ☐ Yes ☐ No
Are you currently breast feeding? ☐ Yes ☐ No
Do you have discomfort around your menses? ☐ Yes
How many pregnancies have you had? ______ How many miscarriages have you had? ______

REVIEW OF SYSTEMS

General:
- ☐ Decreased appetite
- ☐ Fever / chills
- ☐ Weakness
- ☐ Weight Change

Skin:
- ☐ Rash, sores

Respiratory:
- ☐ Chronic Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular:
- ☐ Changes in color of toes or fingers
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Leg Cramps
- ☐ Pain in legs at night
- ☐ Pain with walking
- ☐ Palpitations
- ☐ Sores on feet that heal slowly
- ☐ Swelling in arms or legs
- ☐ Leg pain at rest

Neurological:
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Slurred speech

Hematology:
- ☐ Anemia
- ☐ Easy bruising / bleeding
- ☐ Past transfusion

REASON FOR VISIT / HPI

Years With Varicose / Spider Veins: ________

Vein / Skin Conditions: (Please check all that apply)

- ☐ Small Red "Spider" Veins
- ☐ Flat, Blue-green Veins
- ☐ Bulging Veins
- ☐ Brown Skin Discoloration
- ☐ Abdominal Veins
- ☐ Vaginal Veins
- ☐ Chest or breast veins
- ☐ Facial Veins
- ☐ Ankle Sores

Other: (Please Describe) ____

Leg and Ankle Problems: (If yes, please check leg/s that apply)

Aches	☐ Yes	☐ No	Right ____	Left _____	Both _____
Redness	☐ Yes	☐ No	Right ____	Left _____	Both _____
Heat	☐ Yes	☐ No	Right ____	Left _____	Both _____
Pain	☐ Yes	☐ No	Right ____	Left _____	Both _____
Swelling	☐ Yes	☐ No	Right ____	Left _____	Both _____
Fatigue	☐ Yes	☐ No	Right ____	Left _____	Both _____
Heaviness	☐ Yes	☐ No	Right ____	Left _____	Both _____
Cramps	☐ Yes	☐ No	Right ____	Left _____	Both _____
Itching	☐ Yes	☐ No	Right ____	Left _____	Both _____
Restlessness	☐ Yes	☐ No	Right ____	Left _____	Both _____
Engorgement	☐ Yes	☐ No	Right ____	Left _____	Both _____
Throbbing	☐ Yes	☐ No	Right ____	Left _____	Both _____

Other: ____

VEINTEC VARICOSE VEIN CLINICS: History & Physical Patient Name:____________________

Methods Used To Relieve Leg Discomfort:

- ☐ No Discomfort
- ☐ Leg Elevation
- ☐ Flexion / Extension of Feet
- ☐ Walking
- ☐ Warm Soaks
- ☐ Aspirin
- ☐ Cold Pack
- ☐ Other: ____
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Exercise
- ☐ Compression Hose
  Length: knee thigh pantyhose Brand/Type: ____________
  Strength: __________ How long have you used them? _______
- ☐ Wraps

Per Government request, we are asked to collect the following data for our electronic health records:

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Undefined
- ☐ Declined to report

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Undefined
- ☐ Declined to report

Language:
- ☐ English
- ☐ Spanish
- ☐ Other: (please list) ____