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
__ Cancer: Type_____

__ Hepatitis
__ High Cholesterol
__ HIV / AIDS
__ Hypertension (high blood pressure)
__Kidney Disease
__ Leg Ulcer
__ 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:

- 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: _____ rovider:_____

Patient Height: ____ ft.____in. **Patient Weight**:_____lbs.

ALLERGIES

Allergy to medications or other substances? __ Yes __ No If yes, please list: _____

Prior Flu Vaccine: Date_____ Pneumovax Vaccine: Date_____

MEDICATIONS

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

Drug _____dose (mg)_____frequency_____ Drug _____dose (mg)_____frequency_____

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Drug _____dose (mg)_____frequency_____ Drug _____dose (mg)_____frequency_____

Drug _____dose (mg)_____frequency_____ Drug _____dose (mg)_____frequency_____

Drug _____dose (mg)_____frequency_____ Drug _____dose (mg)_____frequency_____

Vitamins / Minerals _____

_____

Pharmacy Name & Address: _____ Phone#:_____

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

Varicose Veins _____ Please designate relative by: None, Mother, Father, Daughter, Son

Deep Vein Thrombosis _____ _____ Sister, Brother, Maternal Grandfather or Grandmother,

Stroke _____ _____ _____Paternal Grandmother or Grandfather, Maternal Aunt or Uncle

Blood Clotting Problem _____Paternal Aunt or Uncle, Maternal or Paternal Great Aunt or Great Uncle

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SOCIAL: Occupation: _____

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

Walking: __ Increases Discomfort __ Decreases Discomfort

Tobacco Use: __ Smoker __ Dip/Chewing Tobacco **__ Alcohol Use:**

__ Current every day smoker __ Current __ Current some day smoker __ Former

__ Former smoker __ Never smoker __ Unknown if ever smoked __ Current

__ Current status unknown __ Former

Alcohol drinks per day: _____

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
__ Shortness of breath
__ Wheezing
__ Coughing up blood

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

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: _____

Progression of Problem: ___ Worsened, ____ Remained stable, ___Improved, ___ Increased in Size & Severity
Timeline: _____ months / years (please circle appropriate)

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

__ Small Red "Spider" Veins
__ Flat, Blue-green Vein
__ 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: _____

Methods Used To Relieve Leg Discomfort:

__ No Discomfort
__ Leg Elevation
__ Flexion / Extension of Feet
__ Walking
__ Warm Soaks
__ Aspirin
__ Ibuprofen
__ Tylenol
__ Exercise
__ Cold Pack
__ Wraps

Compression | Hose Length: __ knee __ thigh __ pantyhose Brand/Type: _____Strength: _____ How long have you used them? _____

__ Other: _____

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) _____