

Paste Patient label here

PATIENT: _____ **DATE:** _____

Type: Self-Referred Referred by Physician (Name): _____

Chief Complaint: _____

Do you currently have or have you ever had any of the following leg problems:

Symptom	Left Leg	Right Leg
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	<input type="checkbox"/>
Leg heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort	<input type="checkbox"/>	<input type="checkbox"/>
General Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Restless Leg Syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Please answer yes or no:

YES	NO
<input type="checkbox"/>	<input type="checkbox"/> I take medication for my leg symptoms Name of medication(s) _____
<input type="checkbox"/>	<input type="checkbox"/> I wear/have worn compression stockings Light Support <input type="checkbox"/> Prescribed <input type="checkbox"/> (check one) Prescribing Physician: _____
<input type="checkbox"/>	<input type="checkbox"/> Discomfort is relieved by use of compression stockings
<input type="checkbox"/>	<input type="checkbox"/> Discomfort is relieved by elevating my legs
<input type="checkbox"/>	<input type="checkbox"/> Discomfort is relieved by physical activity / walking
I have / have had:	
<input type="checkbox"/>	<input type="checkbox"/> tender, swollen, and painful areas over my veins (phlebitis)
<input type="checkbox"/>	<input type="checkbox"/> a rupture of a swollen or knotted vein (varix)
<input type="checkbox"/>	<input type="checkbox"/> a history of blood clots in veins (deep vein thrombosis)
<input type="checkbox"/>	<input type="checkbox"/> skin color changes over my veins (hemosiderin)
<input type="checkbox"/>	<input type="checkbox"/> persistent pain and swelling in my leg(s) (post phlebotic syndrome)
<input type="checkbox"/>	<input type="checkbox"/> a leg ulcer (venous stasis ulcers)
<input type="checkbox"/>	<input type="checkbox"/> smooth/tight brownish skin above the ankle which causes pain (lipodermatosclerosis)

Please describe any of the above: _____

Please indicate which activities of daily living are affected by your symptoms: (Circle all that apply)

bathing dressing meal preparation household chores work exercise standing sleep other

If circled please explain: _____

Previous Vein Treatment

Have you had any previous vein treatment? Yes No

If Yes, what type/when?

- | | |
|---|--|
| <input type="checkbox"/> Stripping/Ligation _____ | <input type="checkbox"/> Electric Hyfrecaction _____ |
| <input type="checkbox"/> EVLT/VNUS Closure _____ | <input type="checkbox"/> Laser (surface) _____ |
| <input type="checkbox"/> Microphlebectomy _____ | <input type="checkbox"/> UNNA Boot _____ |
| <input type="checkbox"/> Sclerotherapy _____ | <input type="checkbox"/> Compression Stockings _____ |
| <input type="checkbox"/> Pain relief medication _____ | <input type="checkbox"/> Other _____ |

Employment

Type of employment _____ Hours spent standing per day _____ Hours spent sitting per day _____

Pregnancy

Have you had any pregnancies? Yes No If so, how many? _____

Did symptoms worsen after pregnancy? Yes No

May we send a copy of today's consultation to your Primary Care Physician? Yes No

FOR OFFICE USE ONLY

Sclerotherapy _____ Ultrasound for Vein Mapping _____ Compression Hose Rx _____

PERSONAL MEDICAL HISTORY

- YES NO Cardiovascular**
- High blood pressure
 - High cholesterol
 - Heart disease
 - Heart attack
 - Pacemaker or defibrillator
 - Aneurysm – Where? _____
 - Peripheral vascular disease
 - Blood clot – Where? _____
 - Pulmonary embolus
 - Other – List: _____
- YES NO Pulmonary**
- Asthma / breathing difficulties
 - Bronchitis
 - Emphysema
 - Other – List: _____
- YES NO Neurological**
- Stroke
 - TIA (mini-stroke)
 - Other – List: _____
- YES NO Gastrointestinal**
- Bowel / bladder abnormalities
 - Acid Reflux (GERD)
 - Stomach ulcer
 - Gallbladder disease
 - Liver disease / hepatitis
 - Other – List: _____
- YES NO Skin**
- Skin ulcers – Where? _____
 - Rashes, psoriasis, dermatitis
 - Other – List: _____

- YES NO Genitourinary**
- Kidney disease or failure
 - Dialysis – Type: hemo / peritoneal
 - Kidney stones or infection
 - Enlarged prostate
 - Other – List: _____
- YES NO Endocrine/Other**
- Cancer – Type: _____
 - Treatment: _____
 - Diabetes – Type: Type 1 / Type 2
 - Thyroid disease
 - HIV/Aids
 - Other – List: _____
- YES NO Psychiatric**
- Depression / Anxiety
 - Other – List: _____
- YES NO Musculoskeletal**
- Chronic back problems
 - Neck problems
 - Rheumatoid arthritis or other joint disease
 - Gout
 - Osteoporosis
 - Bone or joint surgery in past year?
 - Other – List: _____
- YES NO Head/Neck/ENT**
- Glaucoma
 - Legally blind
 - Hard of hearing
 - Other – List: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No

NAME OF MEDICATION	REACTION

SOCIAL HISTORY

Living Situation (circle all that apply)

Your Home / Assisted Living / Alone / With Family, Friends

Tobacco Use: Never Past Current

Type: Cigarettes Chew Pipe Cigars

How long have you or did you smoke for? _____

Packs per day: _____

Date you quit: _____

If still smoking, do you have plans to quit? Yes No

Children: How many? _____ Ages: _____

Alcohol Use: None Rarely Daily Weekly

How many drinks do you have per day _____ or week _____

Has alcohol been a problem in the past? (circle) Yes / No

Do you use any other substances? Yes No

If so, please list: _____

FAMILY MEDICAL HISTORY (blood relatives only)

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Yes No Heart Disease		Yes No High Blood Pressure	
Yes No Diabetes		Yes No Varicose Veins	
Yes No Cancer – Type:		Yes No Blood Clots	
Yes No Stroke		Yes No Aneurysm	

SURGICAL HISTORY

DATE	DESCRIPTION OF SURGERY	HOSPITAL AND SURGEON

MEDICATIONS (please list all current medications)

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

REVIEW OF SYMPTOMS

Please note any **CURRENT** symptoms below:

YES NO Constitutional Symptoms

- Recent fevers / sweats
- Unexplained weight gain/loss
- Unexplained fatigue / weakness
- Other – List: _____

YES NO Ears / Nose / Throat / Mouth

- Difficulty hearing / ringing in ears
- Difficulty swallowing
- Other – List: _____

YES NO Cardiovascular

- Chest pains / discomfort
- Heart palpitations
- Pain in legs ONLY when walking
- Swelling in legs
- Other – List: _____

YES NO Respiratory

- Shortness of breath
- Cough / wheezing
- Coughing up blood
- Other – List: _____

YES NO Gastrointestinal

- Pain in abdomen
- Heartburn / reflux
- Blood or change in bowel movement
- Nausea / vomiting
- Chronic diarrhea
- Constipation
- Other – List: _____

YES NO Genitourinary

- Frequent urination
- Incontinence
- Painful / burning / bloody urination
- Other – List: _____

YES NO Musculoskeletal

- Back Pain
- Neck Pain
- Joint pain Where? _____
- Muscle pain Where? _____
- Other – List: _____

YES NO Skin

- Rash / Itching
- Change in skin color
- Ulcers / Wounds
- Other – List: _____

YES NO Neurological

- Headaches / migraines
- Sudden change in consciousness
- Transient change in speech
- Transient weakness in arm or leg
- Sudden or severe headache
- Sudden vision change
- Other – List: _____

YES NO Psychiatric

- Anxiety / Stress
- Difficulty Sleeping
- Other – List: _____