Vein & Vascular Institute

Patient Name:_____ Age: ____ DOB:_____ Visit Date:_____

Referring/Consulting Doctor: _____ Referring Doctor Phone:_____

Primary Care Doctor:_____

Reason for visit: Please list when condition started, is it better or worse now and what tests/treatments have been done. Any new medication started?

_____

_____

_____

_____

_____

If you are here for Spider Vein or Varicose Vein evaluation, please fill in the areas below and the section on Vein Disease—page 2.

If you have **pain**, please describe:
Location:_____

Timing (continuous, occasional, episodic):

_____

Duration (min./hrs, am/pm):

_____

Quality (ache, sharp, dull, burning, tiredness, cramp, tender, throbbing, numb, stabbing):

_____

What makes it worse/better:

_____

Severity (1-10):_____

PAST MEDICAL HISTORY: Please Circle Yes or No

High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No	Collapsed Lung	Yes	No
Neuropathy	Yes	No	Emphysema/COPD	Yes	No			
Heart Problems	Yes	No	Cancer	Yes	No	*List any other medical problems.*		
Heart Attack/MI	Yes	No	Bleeding? Ulcer?	Yes	No	_____		
Heart Failure/CHF	Yes	No	Aneurysm	Yes	No	_____		
Stroke/CVA/TIA	Yes	No	DVT/Blood Clot	Yes	No	_____		
High Cholesterol	Yes	No	Varicose Veins	Yes	No			

PAST SURGICAL HISTORY: **Check** ones listed and Please list **ALL** other types and **When:**

☐ Heart Bypass _____

☐ Leg Bypass R / L _____

☐ Vein Surgery R / L_____

☐ Carotid Surgery R / L_____

☐ Aortic Aneurysm _____

☐ Hernia _____

☐ Gallbladder _____

☐ Thyroid _____

☐ Other _____

Has anyone in your family ever had...	Father	Mother	Sibling
Cancer			
Diabetes			
Hypertension			
Heart Problems			
Aneurysms			
Stroke			
Varicose Veins			

SOCIAL HISTORY: Circle

Alcohol Yes No

If yes, how much? _____

Tobacco Use Yes No

Stop? When? _____

If yes, how much? _____

Do you live alone? Yes No

Work Type? _____

Provide List of ALL MEDICATIONS and DOSE you are currently taking—Include all natural supplements.

_____

_____

_____

Allergies:

Pain Meds:

_____

REVIEW OF SYSTEMS: Please circle all that apply

Constitutional: fever chills weight loss/gain—lbs_____
Skin: ulcers rash itching cellulites melanoma basal cell cancer squamous cell cancer
Eyes: temporary loss of vision in one eye blurred vision cataracts glasses
ENT: dentures ear problems hearing aid nose bleeds congestion swallowing problems
Cardiac: chest pain angina chest pain with exertion palpitations leg swelling ankle swelling
Respiratory: short of breath (SOB) wheezing SOB when lie flat
GI: nausea vomiting diarrhea constipation abdominal pain blood in stools
GU: frequency urgency burning when urinate prostate problems kidney disease
Musculoskeletal: pain legs/calf with walking sciatica back pain back disc disease joint pain
Neurologic: dizzy light headed weak or numb one side-arm/let/face headache pass out
Psych: depression anxiety psychosis rehab for drug or alcohol abuse
Endocrine: excessive thirst or urination thyroid disease
Heme/Immune: HIV/AIDS Hepatitis A, B, or C allergies easy bruising clotting disorder

VARICOSE VEINS/SPIDER VEINS: If you are here for this condition, please circle all that apply.

1. Do you experience any of the following:
   - A. Aching pain in your legs? Yes No
   - B. Heaviness Yes No
   - C. Tiredness/fatigue Yes No
   - D. Itching/burning Yes No
   - E. Swollen ankles Yes No
   - F. Leg cramps Yes No
   - G. Restless legs Yes No
   - H. Throbbing Yes No
   - I. Other _____ Yes No
2. Have your veins gotten worse in recent months? Yes No
3. Do you elevate your legs to relieve discomfort? Yes No
4. Do you, or have you used any type of support/compression hose Yes No
5. Do they provide relief? Yes No
6. Are you taking any pain medicine? Yes No
   - A. What type and how often? _____
7. Are you taking any iron supplements or vitamins with iron? Yes No
8. Have you ever had your veins evaluated before? Yes No
   If so, when and where? _____
9. Have you ever had a superficial vein or varicose vein blood clot, phlebitis? Yes No
10. Have you ever had a deep vein thrombosis? Yes No
11. Have you ever had bleeding, bulging ropy veins, swelling, dark skin around the ankles and/or ulcers on the legs? Yes No

Notes: _____

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☐ Hx reviewed with patient Initials_____