



### Medical Information

Date of consultation: \_\_\_\_\_ (office use) MRN: \_\_\_\_\_ CMRN: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referred by: \_\_\_\_\_ Clinic: \_\_\_\_\_ P: \_\_\_\_\_

Primary MD: \_\_\_\_\_ P: \_\_\_\_\_ F: \_\_\_\_\_

### VEIN HEALTH

Which leg is affected? (check one)

Right leg  Left leg  Both legs If both, which is worse? \_\_\_\_R \_\_\_\_L \_\_\_\_Equal

How would you rate the severity of your symptoms? (check one)

Mild to moderate  Moderate to severe

How long have your symptoms been bothering you? (fill in a number)

\_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

When do your symptoms occur? Choose the best answer below. (check one)

Mostly at night  All day  Only during the day  While lying down  At bedtime

Other: \_\_\_\_\_

How would you describe your symptoms? (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aching                    | <input type="checkbox"/> Edema         | <input type="checkbox"/> Skin discoloration |
| <input type="checkbox"/> Awakened at night         | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Spider Veins       |
| <input type="checkbox"/> Bleeding from veins       | <input type="checkbox"/> Heaviness     | <input type="checkbox"/> Swelling           |
| <input type="checkbox"/> Bulging                   | <input type="checkbox"/> Itching       | <input type="checkbox"/> Tender             |
| <input type="checkbox"/> Burning                   | <input type="checkbox"/> Numbness      | <input type="checkbox"/> Throbbing          |
| <input type="checkbox"/> Cramping                  | <input type="checkbox"/> Painful       | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Difficulty healing wounds | <input type="checkbox"/> Restless legs | <input type="checkbox"/> Varicose Veins     |

**Do your symptoms affect your activities of daily living?** Yes No

If yes, which activities are affected: (check all that apply)

- |   |  |                                     |   |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Exercise             | <input type="checkbox"/> Unable to stand >30 min | <input type="checkbox"/> Sex life   | <input type="checkbox"/> Swimming         |
| <input type="checkbox"/> Unable to walk hills | <input type="checkbox"/> Unable to sit > 30 min  | <input type="checkbox"/> Travel     | <input type="checkbox"/> Wearing Shorts   |
| <input type="checkbox"/> Walking > 1 mile     | <input type="checkbox"/> Unable to work          | <input type="checkbox"/> Homemaking | <input type="checkbox"/> Sleep/relaxation |
| <input type="checkbox"/> Walking < 1 mile     | <input type="checkbox"/> Other: _____            |                                     |   |

**Please mark any conservative therapy measure you have tried in the past to relieve your symptoms: (check all that apply)**

- Leg Elevation     Exercise     Pain Medications     Compression Stockings

**If you've tried stockings answer the following:**

Compression    How long?    When did you wear the stockings?

- 20-30 mm Hg    \_\_\_\_\_ Weeks     Nights only     While working     While exercising  
 30-40 mm Hg    \_\_\_\_\_ Months     All day     While traveling     Prior EVLA     Prior Sclero

What type of relief did you experience?     None     Minimal     Intermittent     Significant

**If you've tried Pain Medications, check the meds you've tried below:**

- Tylenol     Ibuprofen     Aspirin     Prescription Meds     Other: \_\_\_\_\_

Relief level from Pain Meds:     None     Minimal     Intermittent     Significant

**Are your symptoms worsened by: (check all that apply)**

\_\_\_\_\_ Walking    \_\_\_\_\_ Exercise    \_\_\_\_\_ Heat    \_\_\_\_\_ Hot Bath    \_\_\_\_\_ Prolonged Standing    \_\_\_\_\_ Prolonged Sitting  
\_\_\_\_\_ Premenstrual    \_\_\_\_\_ Pregnancy    \_\_\_\_\_ Travel    \_\_\_\_\_ Resting    Other: \_\_\_\_\_

**Have you had any vein treatments performed in the past?** Yes No

if yes, please list them below:

Previous Treatments:	<u>circle</u>	<u>Year</u>	<u>Physician</u>
<input type="checkbox"/> Sclerotherapy	right/left	_____	_____
<input type="checkbox"/> Vein Stripping	right/left	_____	_____
<input type="checkbox"/> Phlebectomy	right/left	_____	_____
<input type="checkbox"/> EVLA/Venous Closure	right/left	_____	_____
<input type="checkbox"/> Leg Cramp Treatment	Type: _____		
<input type="checkbox"/> Tx of ulcers, phlebitis, cellulitis or inflammation:	_____		Antibiotic used: _____
<input type="checkbox"/> Other:	_____		

**MEDICAL HISTORY**

Do you see a doctor regularly for any medical condition? \_\_\_ Yes \_\_\_ No If yes, please describe:

Past Medical History (check all that apply) \_\_\_\_\_ none

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> HIV               | <input type="checkbox"/> Pneumonia    |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaundice          | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Leukemia          | <input type="checkbox"/> Ulcers       |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Lung Disease      | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Migraines         | _____                                 |
| <input type="checkbox"/> Colitis           | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Nervous Breakdown |                                       |

Have you had any serious injuries? \_\_\_ Yes \_\_\_ No If yes, list date and type of injury: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list past surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any complications? \_\_\_ Yes \_\_\_ No If yes, what were the complications? \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

Any family history of varicose veins? Yes No

if yes, which family members: (check all that apply)

- Mother  Father  Siblings  Grandmother  Grandfather

Family history of bleeding or clotting disorder? Yes No

if yes, which family members: (check all that apply)

- Mother  Father  Siblings  Grandmother  Grandfather

**SOCIAL HISTORY**

Please select your current employment status:

- Full Time  Part time  Unemployed  Retired  Homemaker

What is your current occupation? \_\_\_\_\_

Do you smoke?

- Current every day  Current some days  Former smoker  Never smoked

if current or former smoker, how many packs per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_

Do you exercise?  Yes  No If yes, please describe: \_\_\_\_\_

**OB/GYN HISTORY (women only)**

Is there a chance that you are pregnant? \_\_\_ Yes \_\_\_ No    How many times have you been pregnant? \_\_\_\_\_

How many children have you delivered? \_\_\_\_\_ Complications? \_\_\_\_\_

**ALLERGIES**

List all allergies:

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking: (including herbs, vitamins, supplements etc.)

Name of medication	Strength	Reason for taking

**MEDICAL CONDITIONS**

**General Health: \_\_\_ none**

- \_\_\_ Recurrent infections
- \_\_\_ Fever
- \_\_\_ Fatigue
- \_\_\_ Recent weight gain or loss
- \_\_\_ Night sweats
- \_\_\_ Decreased appetite

**Mental Health: \_\_\_ none**

- \_\_\_ Depression
- \_\_\_ Anxiety attacks
- \_\_\_ Crying spells
- \_\_\_ Alcohol/drug problems
- \_\_\_ Insomnia
- \_\_\_ Nervousness
- \_\_\_ Suicidal thoughts

**Eyes: \_\_\_ none**

- \_\_\_ Wear glasses/contacts
- \_\_\_ Eye infections
- \_\_\_ Blurred vision

**Lymphatic/Blood Vessels: \_\_\_ none**

- \_\_\_ Excessive bleeding
- \_\_\_ Bruise easily
- \_\_\_ Swollen lymph nodes

**Heart: \_\_\_ none**

- \_\_\_ Chest discomfort
- \_\_\_ Chest tightness
- \_\_\_ Heart murmur
- \_\_\_ Swollen ankles
- \_\_\_ Shortness of breath
- \_\_\_ Rheumatic fever
- \_\_\_ High blood pressure

**Head, ENT, Mouth: \_\_\_ none**

- \_\_\_ Ear infections
- \_\_\_ Headaches
- \_\_\_ Sinus pressure
- \_\_\_ Sore throat
- \_\_\_ Nose bleeds

**Lungs: \_\_\_ none**

- \_\_\_ Difficulty breathing
- \_\_\_ Cough
- \_\_\_ Wheezing
- \_\_\_ Cough blood/mucus
- \_\_\_ Sleep on more than 1 pillow

**Nervous System: \_\_\_ none**

- \_\_\_ Fainting/loss of consciousness
- \_\_\_ Convulsions
- \_\_\_ Seizures
- \_\_\_ Dizziness
- \_\_\_ Memory changes

**Urinary: \_\_\_ none**

- \_\_\_ Burning w/urination
- \_\_\_ Frequent urination
- \_\_\_ Sudden impulse to urinate
- \_\_\_ Irregular periods
- \_\_\_ Clots
- \_\_\_ Cramps
- \_\_\_ Prostate problems

**Muscle/Bone/Joint: \_\_\_ none**

- \_\_\_ Joint pain
- \_\_\_ Stiffness
- \_\_\_ Swelling
- \_\_\_ Muscle pain
- \_\_\_ Muscle cramping/spasm
- \_\_\_ Neck/back pain

**Skin/Breasts: \_\_\_ none**

- \_\_\_ Sore
- \_\_\_ Rash/itching
- \_\_\_ Lumps/growths
- \_\_\_ Changes in moles
- \_\_\_ Hair loss
- \_\_\_ Swollen glands
- \_\_\_ Tender/painful breasts
- \_\_\_ Discharge from breasts

**Stomach/Intestinal: \_\_\_ none**

- \_\_\_ Special diet
- \_\_\_ Change in appetite
- \_\_\_ Heartburn
- \_\_\_ Nausea/vomiting
- \_\_\_ Problems swallowing
- \_\_\_ Black stool
- \_\_\_ Ulcers
- \_\_\_ Constipation

Other: Please describe any other medical conditions you may have: \_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL MEDICAL INFORMATION:**

Please share any details about your health that you feel may be relevant and not previously mentioned: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By signing below, I acknowledge that the information I have provided is correct to the best of my knowledge.

\_\_\_\_\_

Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date