spartz VEIN CLINIC

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Medical Information

Date of consultation: _____ (office use) MRN: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____Date of birth: _____Age: _____
Height: _____ Weight: _____

Referred by: _____ Clinic: _____P: _____

If you want records sent to Primary MD: _____ Ph: _____ Fax: _____

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)

☐ Aching	☐ Edema	☐ Skin discoloration
☐ Awakened at night	☐ Fatigue	☐ Spider Veins
☐ Bleeding from veins	☐ Heaviness	☐ Swelling
☐ Bulging	☐ Itching	☐ Tender
☐ Burning	☐ Numbness	☐ Throbbing
☐ Cramping	☐ Painful	☐ Ulcers
☐ Difficulty healing wounds	☐ Restless legs	☐ Varicose Veins

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

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

☐ Exercise ☐ Unable to stand >30 min ☐ Sex life ☐ Swimming

☐ Unable to walk hills ☐ Unable to sit > 30 min ☐ Travel ☐ Wearing Shorts

☐ Walking > 1 mile ☐ Unable to work ☐ Daily Chores ☐ Sleep/relaxation

☐ Walking < 1 mile ☐ 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 Stocking ☐ None

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: circle Year Physician

☐ Sclerotherapy right/left _____ _____

☐ Vein Stripping right/left _____ _____

☐ Phlebectomy right/left _____ _____

☐ EVLA/Venous Closure right/left _____ _____

☐ Leg Cramp Treatment Type: _____

☐ Tx of ulcers, phlebitis, cellulitis or inflammation: _____Antibiotic used: _____

☐ Other: _____

MEDICAL HISTORY

Do you see a doctor regularly for any medical condition? ____ Yes ____ No If yes, please describe:
vdfg
_____

Past Medical History (check all that apply) _____ none

☐ AIDS	☐ Deep Vein Thrombosis	☐ High Blood Pressure	☐ Pneumonia
☐ Anemia	☐ Diabetes	☐ HIV	☐ Seizures
☐ Bleeding Disorder	☐ Depression	☐ Jaundice	☐ Stroke
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Ulcers
☐ Cataracts	☐ Headaches	☐ Leukemia	☐ Other: _____
☐ Clotting Disorder	☐ Heart Disease	☐ Lung Disease	_____
☐ Colitis	☐ Hepatitis	☐ Migraines	

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 ☐ Student ☐ Other

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

Heart: ___ none

____Chest discomfort

____Chest tightness

____Heart murmur

____Swollen ankles

____Shortness of breath

____Rheumatic fever

____High blood pressure

Muscle/Bone/Joint: ___ none

____Joint pain

____Stiffness

____Swelling

Mental Health: ___ none

____Depression

____Anxiety

____Crying spells

____Alcohol/drug problems

____Insomnia

____Nervousness

____Suicidal thoughts

Head, ENT, Mouth: ___ none

____Ear infections

____Headaches

____Sinus pressure

____Sore throat

____Nose bleeds

Nervous System: ___ none

____Fainting/loss of consciousness

____Convulsions

____Seizures

____Dizziness

____Memory changes

Eyes: ___ none

____Wear glasses/contacts

____Eye infections

____Blurred vision

Lymphatic/Blood Vessels: ___ none

____ Excessive bleeding

____ Bruise easily

____ Swollen lymph nodes

Lungs: ___ none

____ Difficulty breathing

____ Cough

____ Wheezing

____ Cough blood/mucus

____ Trouble breathing when sleeping

Urinary: ___ none

____Burning w/urination

____Frequent urination

____Sudden impulse to urinate

____Irregular periods

____Clots

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____Muscle pain

____Muscle cramping/spasm

____Neck/back pain

____Cramps

____Prostate problems

Skin/Breasts: ___ none

____Discharge from breasts
____Rash/itching
____Lumps/growths
____Changes in moles
____Hair loss
____Swollen glands
____Tender/painful breasts

Stomach/Intestinal: ___ none

____Special diet
____Change in appetite
____Heartburn
____Nausea/vomiting
____Problems swallowing
____Black stool
____Ulcers

____Use antacids
____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