BELLAMAH VEIN CENTER

2975 Stockyard Road, Suite 200 — Missoula, MT 59808 — 406.541.3200
575 Sunset Blvd, Suite 104 — Kalispell, MT 59901 — 406.541.3200

Confidential - *Fill out in Black or Blue Pen*

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Current Height: _____ ft. _____ in. Current Weight: _____ lbs

What is your reason for your visit today? _____

Current symptoms: (Please check all that apply)

- ☐ Aching / Pain
- ☐ Heaviness
- ☐ Tiredness / Fatigue
- ☐ Itching / Burning / Warmth
- ☐ Leg cramping
- ☐ Throbbing
- ☐ Leg restlessness
- ☐ Swelling
- ☐ Skin discoloration
- ☐ Skin or ulcer problems
- ☐ Bleeding from veins

Check if you've had any of the following:

- ☐ Heart disease
- ☐ Peripheral arterial disease (PAD)
- ☐ HIV
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Kidney disease
- ☐ Auto-immune
- ☐ Leg trauma / surgery
- ☐ Asthma / COPD
- ☐ Major surgery / hospitalizations:

_____

_____

_____

Annual Immunization:

Did you receive a flu shot during the "Flu season" (August-March)? ☐ Y ☐ N If yes, date of shot _____

Did you receive a Pneumoccocal shot? ☐ Y ☐ N If yes, date of shot _____

Please check below if you have, or have had, any of the following:

A prior evaluation for your veins _____ (yr) Previous vein surgery or laser treatments _____ (yr) _____ Right _____ Left

Previous vein injections? _____ (yr) _____ Right _____ Left Bleeding from a vein? _____ (yr) _____ Right _____ Left

A leg ulceration? _____ (yr) _____ Right _____ Left

Superficial thrombophlebitis or an inflammation of a vein? _____ (yr) _____ Right _____ Left _____ (Location)

Any type of blood clot? _____ (yr) _____ Right _____ Left _____ (Location)

Any type of clotting disorder? _____ (Diagnosis)

Diagnosed with a PFO (patent foramen ovale?) ☐ Y ☐ N

Restless Legs Syndrome: (Please check all that apply)

- ☐ Do you find the need to move your leg(s) to relieve an uncomfortable feeling?
- ☐ Do(es) your leg(s) feel better when moving it (them) or walking?
- ☐ Are your legs symptoms worse when sitting or resting, without elevating your leg(s)?
- ☐ Are your leg symptoms worse later in the day or night?

Conservative Measures Used Currently or Previously: (Please check all that apply)

- ☐ Exercise
- ☐ Weight loss
- ☐ Leg elevation
- ☐ Pain medication
- ☐ Job change
- ☐ Have you worn compression stockings or leg wraps?
  If yes, what was the strength of the stockings?
  _____ mmHg

Women Only: (Please check all that apply)

- ☐ Are you pregnant or considering a pregnancy sometime in the future?
- ☐ Are you breast feeding?
- ☐ Are your legs more painful with menstruation?
- ☐ Do you have bulging veins as a result from pregnancy?

Symptoms: Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness. numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Itching
- ☐ Scars
- ☐ Sore that won't heal

Family Health History: (Fill in the health information about your family)

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				

A family history of vein disease? _____

A family history of blood clots? _____

A family history of a clotting disorder? _____

Hospitalization(s) and Surgeries

Year	Hospital Name	Reason for Hospitalization and Outcome

Health Habits: (Please check all that apply)

Alcohol ☐ Y ☐ N Tobacco Use ☐ Y ☐ N Inhaled Marijuana ☐ Y ☐ N Exercise ☐ Y ☐ N

Occupation: _____

Allergies and Allergic Responses: or NO Known drug allergies?

_____ Rash / Nausea / Vomiting | Diarrhea | Shortness of breath | Anaphylaxis | Other: _____

_____ Rash / Nausea / Vomiting | Diarrhea | Shortness of breath | Anaphylaxis | Other: _____

_____ Rash / Nausea / Vomiting | Diarrhea | Shortness of breath | Anaphylaxis | Other: _____

Current Medications: Include prescription drugs, over-the-counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements

	Medication	Dose	Frequency	Route
1.				
2.				
3.				
4.				

Preferred Pharmacy (Name and Location) _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

ACCREDITED FACILITY · IAC · VASCULAR TESTING ·

_____ Patient Signature _____ Date

_____ Physician Signature _____ Date