

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 Pneumococcal 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.

- | | | | | | | | | | | | |
|--|------------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|------------------------------------|--|--|---|
| <p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p>MUSCLE/JOINT/BONE
Pain, weakness, numbness in:</p> <table border="0"> <tr> <td><input type="checkbox"/> Arms</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Legs</td> </tr> <tr> <td><input type="checkbox"/> Feet</td> <td><input type="checkbox"/> Neck</td> </tr> <tr> <td><input type="checkbox"/> Hands</td> <td><input type="checkbox"/> Shoulders</td> </tr> </table> | <input type="checkbox"/> Arms | <input type="checkbox"/> Hips | <input type="checkbox"/> Back | <input type="checkbox"/> Legs | <input type="checkbox"/> Feet | <input type="checkbox"/> Neck | <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders | <p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood | <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <p>EYE, EAR, NOSE, THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision | <ul style="list-style-type: none"> <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos <p>SKIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Itching <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hips | | | | | | | | | | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Legs | | | | | | | | | | |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Neck | | | | | | | | | | |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders | | | | | | | | | | |

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.



Patient Signature

Date

Physician Signature

Date