

Patient Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Reason for Visit:

**Reason for Visit**

Please list when condition started, is it better or worse now and what tests/treatments have been done. \_\_\_\_\_

Have you started any new medications? \_\_\_\_\_

**Pain**

If you have pain with your condition, using the scale below, please check the box that best represents the severity of your pain

No Pain		Mild		Moderate		Severe		Excruciating	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>

Location of pain: \_\_\_\_\_ Duration (mins/hrs, a.m./p.m.) \_\_\_\_\_

What makes the pain worse or better? \_\_\_\_\_

Timing: (continuous, occasional, episodic) \_\_\_\_\_

**Past Medical History**

Are you currently or have you been treated for any of the following:

- |                     |                              |                             |                  |                              |                             |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neuropathy          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema/COPD   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Problems      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack/M.I.   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding? Ulcer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Failure/CHF   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke/CVA/TIA      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | DVT/Blood Clot   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Cholesterol    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Collapsed Lung   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- Have you ever had vein stripping surgery?  Yes  No If yes, which leg and when? \_\_\_\_\_
- Have you ever had vein injections?  Yes  No If yes, which leg and where on the leg? \_\_\_\_\_
- Have you ever had a blood clot?  Yes  No If yes, which leg and when? \_\_\_\_\_
- Have you ever had phlebitis?  Yes  No If yes, which leg and when? \_\_\_\_\_

## Past Surgical History

Have you ever had the following surgeries and if so when:

Heart Bypass	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Leg Bypass (Right/Left)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Gallbladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Vein Surgery (Right/Left)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Thyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Carotid Surgery (Right/Left)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Aortic Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other: _____				When: _____			

## Family History

Has check if anyone in your family had the following:	Father	Mother	Brother/Sister
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins, Spider Veins or Leg Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Other Serious Illness Not Listed Above (explain): _____			

## Social History

Do you drink alcohol?  Yes  No

Do you smoke or use tobacco?  Yes  No

Do you live alone?  Yes  No

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

## Medication List & Allergies

Please provide a list of ALL MEDICATIONS and DOSE you are currently taking (including natural supplements):

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Are you allergic to any drugs or medicines? If so, please list: \_\_\_\_\_

Do you have any other allergies (ie. latex) that we should be aware of? \_\_\_\_\_

## Review of Systems

Please check any that describe your current health status:

### GENERAL

- |  |   |  |                                 |
|--|---|--|---------------------------------|
| <input type="checkbox"/> Recent weight gain        | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Fever           | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Cancer of any kind: _____ |   | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Polio  |

### SKIN

- |   |                               |   |  |
|---|-------------------------------|---|--|
| <input type="checkbox"/> Skin Ulcers        | <input type="checkbox"/> Rash | <input type="checkbox"/> Itching            | <input type="checkbox"/> Cellulitis        |
| <input type="checkbox"/> Skin Cancer: _____ |                               | <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Change in Texture |

### NEUROLOGICAL

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Light headed/dizzy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Weakness             |
| <input type="checkbox"/> Memory Loss        | <input type="checkbox"/> Numbness | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Loss of Coordination |

**EYES, EARS, NOSE & THROAT**

- |                                     |  |   |                                      |
|-------------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> Dentures   | <input type="checkbox"/> Ear Problems        | <input type="checkbox"/> Hearing Aid    | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Swallowing Problems | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Sore Throat |

**ENDOCRINE**

- |  |                                   |   |  |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Excessive Urination |
|--|-----------------------------------|---|--|

**RESPIRATORY**

- |  |                                    |                                      |                                     |
|--|------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing  | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Chest Pain |

**CARDIOVASCULAR**

- |   |                                       |   |  |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Angina       | <input type="checkbox"/> Palpitations     | <input type="checkbox"/> Leg Swelling        |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Perfuse Sweating | <input type="checkbox"/> Irregular Heartbeat |

**GASTROINTESTINAL**

- |   |  |                                   |                                       |
|---|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Ulcers   | <input type="checkbox"/> Colitis      |

**GENITOURINARY**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood in Urine |
|--|--|---|---|

**MUSCULOSKELETAL**

- |   |                                   |                                     |  |
|---|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Leg Pain while Walking | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Back Disc Disease |
|---|-----------------------------------|-------------------------------------|--|

**PSYCHOLOGICAL**

- |                                     |                                  |                                    |  |
|-------------------------------------|----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Chemical Dependency |
|-------------------------------------|----------------------------------|------------------------------------|--|

**HEMATOLOGIC/IMMUNE**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> HIV-AIDS          | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Allergies         | <input type="checkbox"/> Easy Bruising      |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Sickle Cell Anemia |

**Varicose Veins & Spider Veins (if presenting for this condition)**

Do you experience any of the following in your leg(s):

- |  |                              |                             |                               |                                |
|--|------------------------------|-----------------------------|-------------------------------|--------------------------------|
| Aching pain in your legs?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Heaviness  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Tiredness / Fatigue  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Itching / Burning  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Swollen Ankles   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Leg Cramps   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Restless Legs  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Throbbing  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Other (describe):  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Have your veins become worse in recent months?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| Do you elevate your legs to relieve discomfort?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| Do you, or have you used any type of support or compressions hose?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| If yes, do they provide relief?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| Are you taking any pain medicine?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| If yes, what type and how often?   |                              |                             |                               |                                |
| Are you taking any iron supplements or vitamins with iron?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| Have you ever had your veins evaluated before?                               |                              |                             |                               |                                |
| If yes, when and where?  |                              |                             |                               |                                |
| Have you ever had a superficial vein or varicose vein blood clot, phlebitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |
| Have you ever had a deep vein thrombosis?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                                |