

IT IS IMPORTANT THAT THIS FORM IS FILLED OUT COMPLETELY. THANK YOU.

NAME _____ DATE (OF OFFICE VISIT) _____

GENDER: FEMALE MALE HEIGHT _____ WEIGHT _____ AGE _____

◆ REASON FOR VISIT:

- Varicose veins/legs Spider veins/legs Spider veins/face Vascular birthmark
 Other _____

If you have a vascular birthmark, has it changed in size? YES NO

If you have varicose or spider veins/legs, when did they occur?

- At age _____ Before pregnancy YES NO After pregnancy YES NO
 After trauma YES NO After taking birth control or hormonal drug therapy YES NO
 Other _____

Please describe your expectations of therapy _____

◆ PAST TREATMENT:

Have you ever been treated for the above problem(s)? YES NO

If yes, by whom? _____

When? _____ What method? Sclerotherapy PhotoDerm Laser Surgery

Have you ever worn support hose? YES NO Do you currently wear support hose? YES NO

Length of time support hose worn _____

Do you use medications to relieve your leg pain? YES NO

If yes, list medication _____

How do you take the medication: on a daily basis or as needed

◆ FOR VARICOSE AND SPIDER VEINS OF THE LEGS COMPLETE THIS SECTION:

	RIGHT LEG LEFT LEG			RIGHT LEG LEFT LEG	
<u>Do you now have:</u>			<u>The leg pain is better with...</u>		
-pain in your thigh?	<input type="checkbox"/>	<input type="checkbox"/>	-elevation of the leg	<input type="checkbox"/>	<input type="checkbox"/>
-pain in your calf?	<input type="checkbox"/>	<input type="checkbox"/>	-compression hose	<input type="checkbox"/>	<input type="checkbox"/>
-pain in your foot?	<input type="checkbox"/>	<input type="checkbox"/>	-medication	<input type="checkbox"/>	<input type="checkbox"/>
-ulcer on your legs?	<input type="checkbox"/>	<input type="checkbox"/>	-exercise/walking	<input type="checkbox"/>	<input type="checkbox"/>
-fatigue in your legs?	<input type="checkbox"/>	<input type="checkbox"/>	<u>Your pain feels like...</u>		
<u>The pain is made worse with...</u>			-an ache/tiredness/heaviness	<input type="checkbox"/>	<input type="checkbox"/>
-standing	<input type="checkbox"/>	<input type="checkbox"/>	-a cramp	<input type="checkbox"/>	<input type="checkbox"/>
-heat	<input type="checkbox"/>	<input type="checkbox"/>	-a burning	<input type="checkbox"/>	<input type="checkbox"/>
-before menses	<input type="checkbox"/>	<input type="checkbox"/>	-numbness	<input type="checkbox"/>	<input type="checkbox"/>

Do your symptoms, caused by your varicose and/or spider veins, interfere with your work?

YES NO COMMENTS _____

◆ PATIENT HISTORY:

VENOUS HISTORY: Please check if you have a history of:

- Phlebitis Leg ulcers Pulmonary embolus Use of anticoagulants (Heparin/Coumadin)
 Blood clots Leg injury Leg bone fracture Family history of varicose/spider veins

SURGICAL HISTORY: List surgical procedures you have had:

PROCEDURE	YEAR	OUTCOME
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY: Please check if you currently have or have had a history of the following:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart failure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty healing | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Leukemia/Lymphoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Major accident | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Difficulty with anesthetic given at the dentist office | | | |
| <input type="checkbox"/> History of unusual family illnesses _____ | | | |

Other medical condition(s) not listed _____

◆ **CURRENT MEDICATIONS:**

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

◆ **ALLERGIES:**

◆ **SOCIAL HISTORY:**

ACTIVITY: Occupation _____ Do you exercise regularly? YES NO

If yes, how? _____
Daily average time spent sitting? _____%/ standing? _____%

SMOKING: Do you smoke cigarettes? YES NO If yes, # of packs/day _____

ALCOHOL: Do you consume alcohol? YES NO If yes, # of drinks/day _____

◆ **FOR FEMALE PATIENTS:**

Are you pregnant? YES NO UNSURE Date of last menstrual period _____

of pregnancies _____ # of children _____ Are you currently breastfeeding? YES NO

Are you taking birth control pills or other hormones? YES NO

Have you had a tubal ligation or hysterectomy? YES NO

◆ **FOR PHYSICIAN USE:**

COMMENTS: _____

I have reviewed the above information, completed by the patient, with the patient.

PHYSICIAN SIGNATURE: _____