



Patient Information

Date _____ Date of Birth _____ Sex Male _____ Female _____

Daytime Phone _____ Work Phone _____

How did you hear about us?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Friend or family member | <input type="checkbox"/> Current Patient | <input type="checkbox"/> Phonebook |
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Website | <input type="checkbox"/> Other _____ |

Vein History

Prior Evaluation Yes No Results _____

Prior Testing Yes No Results _____

Does your work require prolonged:

- | | | |
|-----------------------------------|-------|-------|
| | Yes | No |
| <input type="checkbox"/> Sitting | _____ | _____ |
| <input type="checkbox"/> Standing | _____ | _____ |

Treatment History

Treatments you have tried in the past:

	R leg	L leg	# of years
<input type="checkbox"/> Over the Counter Compression Stockings	_____	_____	_____
<input type="checkbox"/> Prescription Compression Stockings	_____	_____	_____
<input type="checkbox"/> Elevation	_____	_____	_____
<input type="checkbox"/> Ambulatory Phlebectomy	_____	_____	_____
<input type="checkbox"/> Surgery/Stripping	_____	_____	_____
<input type="checkbox"/> Injections	_____	_____	_____
<input type="checkbox"/> Laser Treatment	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

Symptoms

	R leg	L leg	# of years
<input type="checkbox"/> Aching	_____	_____	_____
<input type="checkbox"/> Bleeding	_____	_____	_____
<input type="checkbox"/> Burning	_____	_____	_____
<input type="checkbox"/> Cramps	_____	_____	_____
<input type="checkbox"/> Discoloration	_____	_____	_____
<input type="checkbox"/> Heaviness/Tiredness	_____	_____	_____
<input type="checkbox"/> Numbness	_____	_____	_____
<input type="checkbox"/> Pain	_____	_____	_____
<input type="checkbox"/> Restless Leg	_____	_____	_____
<input type="checkbox"/> Thrombophlebitis	_____	_____	_____
<input type="checkbox"/> Ulcers	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

Medications

Are you taking any of the following medications?

- Aspirin, Motrin, Ibuprofen, Nuprin, Etc.
- Blood Thinners (Coumadin, Etc.)
- Hormones or Contraceptives
- Chemotherapy
- Thyroid Medication
- Insulin
- Appetite Suppressants
- Blood Pressure

Yes	No
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thrombus/Clot |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures |

Family History

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Thrombus/Clot |
|---|------------------------------------|--|

Social History

- | | | |
|-----------------------------|------------------------------|-----------------------------|
| Smoker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Previous Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Planning Future Pregnancies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Allergies

Are you allergic to any of the following?

- Medications
Explain _____
- Latex
Explain _____
- Lidocaine
Explain _____

Miscellaneous

Is there any additional information you feel that you feel would be pertinent?

Signature _____ Date: _____