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CONFIDENTIAL HEALTH & VASCULAR HISTORY

PATIENT INFORMATION

Name: _____ Date: _____

Age: _____ Sex: _____ Date of Birth: _____

HOW DID YOU HEAR ABOUT US?

Referring Doctor: _____

Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Aspen Club | <input type="checkbox"/> Health Beat |
| <input type="checkbox"/> Bus Advertising | <input type="checkbox"/> Internet/Website |
| <input type="checkbox"/> Bus Shelter | <input type="checkbox"/> KUNC |
| <input type="checkbox"/> Coloradoan | <input type="checkbox"/> Style Magazine |
| <input type="checkbox"/> Discover Magazine | <input type="checkbox"/> Vein Screening |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Greeley Tribune | <input type="checkbox"/> Your Health |
| <input type="checkbox"/> Other: _____ | |

PRIMARY CARE INFORMATION

Primary Care Physician: _____ Phone #: _____

PROBLEM: _____

Years with varicose/spider veins: _____

Which leg bothers you more? Right Left

SYMPTOMS:

Please check all that apply to your legs or ankles:		Right/Left	
<input type="checkbox"/> Unsightly or bulging veins:		R L	<input type="checkbox"/> Skin ulcerations R L
Association with Pregnancy? _____			Healed? _____
			Unhealed? _____
			Duration: _____
<input type="checkbox"/> Ache/Pain	R L		<input type="checkbox"/> Bleeding from veins R L
<input type="checkbox"/> Cramps	R L		Transfusion? _____
<input type="checkbox"/> Swelling	R L		<input type="checkbox"/> Abdominal Veins
<input type="checkbox"/> Tiredness/Heaviness/Fatigue	R L		<input type="checkbox"/> Pelvic Symptoms
<input type="checkbox"/> Restlessness	R L		
<input type="checkbox"/> Itching/Burning	R L		
<input type="checkbox"/> Dermatitis (Eczema)	R L		
<input type="checkbox"/> Pigmentation (Discoloration) below knee	R L		

WORSENING OF SYMPTOMS:

Please check all that further exacerbate your symptoms:

- Prolonged immobility (sitting or standing)
- Walking/Exercise
- Heat
- Pre-menstrual
- Pregnancy
- Sleeping at night

CONSERVATIVE THERAPY:

- Elevation Relief? Yes No
- Exercise Relief? Yes No
- Weight loss
- Flexion/Extension of feet
- Avoidance of *immobility* (prolonged standing or sitting)
- Warm soaks
- Cold packs
- Compression stockings How long? _____
- Pain medication/analgesics
- Other: _____

MEDICAL HISTORY

Do **you** have a history of?

Please check all that apply:

- Atherosclerosis
- Bleeding/Blood disorder
- Constipation
- Deep vein thrombosis/clot
- Diabetes; insulin dependent
- Other: _____
- Hypertension
- Lupus
- Pulmonary embolus
- Superficial thrombophlebitis
- Trauma to legs
- Easy bruising

Is there a history of spider or varicose veins in **your family**?

- Mother
- Siblings
- Grandparents
- Father
- Aunt/Uncle
- Child

Is there a history of deep venous thrombosis, stroke, or clotting disorders in **your family**?

- Mother
- Siblings
- Grandparents
- Father
- Aunt/Uncle
- Child

OTHER MEDICAL INFORMATION

Do you have allergies or sensitivities to tape, iodine, or latex?

List all: _____

- Are you pregnant or planning to be soon? Yes No
- Are you currently breastfeeding? Yes No
- Do you take oral contraceptive or hormone-replacement therapy on a regular basis? Yes No

Do your symptoms interfere with activities of daily living? Yes No

Have you been treated for your veins before? Yes No
By whom? _____ When? _____

What method?

- | | |
|--|--|
| <input type="checkbox"/> Ligation | <input type="checkbox"/> Ambulatory Phlebectomy |
| <input type="checkbox"/> Stripping | <input type="checkbox"/> Sclerotherapy (Injections) |
| <input type="checkbox"/> Radiofrequency Closure® | <input type="checkbox"/> Ultrasound-Guided Sclerotherapy |
| <input type="checkbox"/> Laser Ablation | <input type="checkbox"/> Laser for Spider Vein |
| <input type="checkbox"/> Other: _____ | |

What have your results been? _____

What about your legs would you most like to correct? _____
