VENOUS EVALUATION

Patient Name: Last_____First_____Date: _____

Date of Birth:_____/____/____ Age: _____ Height: _____ Weight: _____ Sex: Female / Male

Primary Care Physician: _____

Allergies or reactions: _____

- ☐ Past Medical History:
- ☐ Cancer (if yes which type? Are you currently undergoing any treatments?)
  _____
- ☐ Lung Disease (Asthma, Emphysema, Chronic bronchitis, other)_____
- ☐ Heart disease (Heart Attack, Coronary artery disease, arrhythmia, murmur, enlarged heart, heart failure, other)_____
- ☐ Diabetes (Insulin or Non-Insulin dependent)
- ☐ Hypertension (High blood pressure)
- ☐ Hypercholesterolemia (High cholesterol/triglycerides)
- ☐ Stroke
- ☐ Blood clots (Phlebitis, DVT)
- ☐ Thrombophilia (HIT, Factor V Leiden, Protein C/S deficiency, homocysteinemia, other)_____
- ☐ Infectious diseases (HIV, Hepatitis, tuberculosis, other)_____
- ☐ Arthritis (osteo/rheumatoid)
- ☐ Neurological disorder (Migraines, Multiple Sclerosis, Myesthenia Gravis, Parkinson's disease, Alzheimer's disease, other)_____
- ☐ Peripheral Arterial disease
- ☐ Thyroid dysfunction (if yes, please specify)_____
- ☐ Gastrointestinal condition (GERD, PUD, Colitis, Liver disease, hemorrhoids, other)_____
- ☐ Skin disorders (psoriasis, eczema, Idiopathic thrombocytopenic purpura, other)_____

Medications:

- ☐ Blood thinners (Aspirin, Plavix, Coumadin, other)_____
- ☐ Hormone replacement therapy (HRT); Contraception (oral, injection, other)_____
- ☐ Other prescriptions_____
- ☐ Other over the counter_____
- ☐ Vitamins/supplements_____

Past Surgical History:

- ☐ Vein surgery (Stripping & Ligation, Phlebectomy, Sclerotherapy, Laser). Which leg? When? _____
  - Please specify_____
- ☐ Stents (heart, carotid, peripheral/legs or arms) please specify_____
- ☐ Other _____

VENOUS EVALUATION

Patient Name: Last_____First_____Date: _____

Date of Birth:_____/____/____ Age: _____ Height: _____ Weight: _____ Sex: Female / Male

Primary Care Physician: _____

Social history:

- ☐ Smoking (yes/no) please specify_____
- ☐ Alcohol (yes/no) please specify_____
- ☐ Illegal drugs (yes /no) please specify_____
- ☐ Work history (standing occupation i.e. teacher, hair dresser, retail, other)_____
- ☐ Athletic history (sports, if yes which? Injuries?)_____
- ☐ Exercise history (if yes please specify i.e. weight lifting, running, kick boxing, other)_____
- ☐ Ambulatory status (Bedridden, wheelchair, walker, cane, limp, none)_____

Family history:

- ☐ Varicose veins (who?)_____
- ☐ Blood clots (who?)_____
- ☐ Leg ulcers (who?)_____

Child rearing history (females only):

- ☐ Are you pregnant? (yes/no)
- ☐ Do you intend to become pregnant in the next year? (yes/no)
- ☐ Are you currently breast feeding? (yes/no)
- ☐ How many pregnancies have you had? _____
- ☐ How many births? _____

Venous Review of systems:

- ☐ Which leg is affected: Left Right Both
- ☐ Type of veins: Bulging veins Blue surface veins Spider veins
- ☐ Symptoms: Pain Aching Throbbing Cramping Itching Burning Heaviness Fatigue Restless legs
- ☐ Signs: Warmth Redness Bluish discoloration Ankle swelling Leg ulcers Fluid leakage Vein bleeding
- ☐ Signs/Symptoms worse at end of day? (yes/no)
- ☐ Signs/Symptoms worse around menstrual cycle? (yes / no / N/A)

Venous Symptomatic management:

- ☐ Do you wear or have you worn compression stockings? When? For how long? Did they help?
- ☐ Do you take medicine for pain? If yes, what do you take? How often?
- ☐ Does anything else relieve your symptoms?

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Primary Care Physician: _____

Please state your personal priority and goal for vein treatment.

_____
_____
_____
_____
_____

Signature: _____Date:_____