THE NEW JERSEY
VEIN AND VASCULAR CENTER

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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, myasthenia 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) or 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

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 one? 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 ☐
- ☐ Types of veins: bulging veins ☐ blue surface veins ☐ spider veins ☐
- ☐ Symptoms: pain ☐ aching ☐ throbbing ☐ cramping ☐ itching ☐ burning ☐ heaviness ☐ fatigue ☐ restless legs ☐

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?

Please state your personal priority and goal for vein treatment:

Signature Date