THE NEW JERSEY
VEIN AND VASCULAR CENTER

390 Route 10 West, North Building, Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

VENOUS EVALUATION

Patient Last Name: **First Name:** **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 heart 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
  Please specify.
- ☐ Other over the counter
  Please specify.
- ☐ Vitamins/Supplements
  Please specify.

Past Surgical History:

☐ Vein surgery (stripping & ligation, phlebectomy, sclerotherapy, laser)
Which leg? When? Please specify.

☐ Stents (hearts, 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, hairdresser, retail, other)
☐ Athletic history (if yes, please specify, i.e. sports. 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 breastfeeding? (Yes/No)
☐ How many pregnancies have you had?
☐ How many births?

Venous Review of Symptoms:

☐ Which leg is affected?	☐ left	☐ right	☐ both			
☐ Types of veins:	☐ bulging veins	☐ spider veins	☐ blue surface veins			
☐ Symptoms:	☐ pain	☐ aching	☐ throbbing	☐ cramping	☐ itching	☐ burning
	☐ heaviness	☐ leg swelling	☐ 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:**