Name:_____
Date:_____Date of Birth:_____Age:_____

CENTER FOR VEIN DISEASE

Patient History

Symptoms: ***(Please check if yes)***

	R	L
Aching / pain in legs	☐	☐
Heaviness	☐	☐
Tiredness / fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your symptoms worse with or after activity? ☐
Do your symptoms keep you from doing anything? ☐

Check if you've had any of the following:

Heart disease ☐
Peripheral arterial disease ☐
HIV ☐
Hepatitis ☐
High blood pressure ☐
Diabetes ☐
Cancer ☐
Leg trauma / surgery ☐
Asthma/COPD ☐
Major surgery / hospitalizations: ☐

_____
_____

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

☐ Was diagnosed with PAD in past
☐ Have/had cramping leg pain that worsens with walking, forcing me to stop walking
☐ Feet/toes become pale and painful with exercise or when elevating them
☐ Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

☐ Exercise ☐ Weight loss
☐ Leg elevation ☐ Job change
☐ Pain medication

Have you worn compression stockings or leg wraps? ☐ Yes ☐ No
If yes, what was the strength of the stockings?_____mmHg
If yes, how long did you wear compression stockings? _____ months____years

Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling? ☐
Do(es) your leg(s) feel better when moving it (them) or walking? ☐
Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? ☐
Are your leg symptoms worse later in the day or night? ☐

Please check below if you have, or have had, any of the following:

☐ A prior evaluation for your veins:_____*(yr)*
☐ Previous vein surgery or laser treatments:_____*(yr)*____*R*____*L*
☐ Previous vein injections:_____*(yr)*____*R*____*L*
☐ Bleeding from a vein:_____*(yr)*____*R*____*L*
☐ A leg ulceration:_____*(yr)*____*R*____*L*
☐ Superficial thrombophlebitis or an inflammation of a vein:_____*(yr)*____*R*____*L*_____*(Location)*
☐ Any type of blood clot:_____*(yr)*____*R*____*L*_____*(Location)*
☐ Any type of clotting disorder:_____*(Diagnosis)*
☐ Migraines with aura
☐ Diagnosed with a PFO (patent foramen ovale)

☐ A family history of vein disease
☐ A family history of leg ulceration
☐ A family history of blood clots
☐ A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? ☐
Are you breast-feeding? ☐ Are your legs more painful associated with menstruation? ☐
Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? ☐
Number of Pregnancies:_____Deliveries:_____Miscarriages:_____Children's ages:_____

Provider reviewed with patient:_____**Date:**_____

CENTER FOR VEIN DISEASE

Today's Date:_____ **Your Appointment Time:**_____ **a.m. / p.m. Clinic Location:**_____

Date of Birth:_____

Race	**Ethnicity**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State
Preferred Primary Language: ☐English ☐Other:_____ ☐ Decline to State	
Weight:_____lbs. and **height:**_____ft._____in	

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?

Date of Last Flu Shot____/____ (Month/Year) ☐ No/Refused ☐Decline for Medical Reason → ☐ Allergy ☐ Other Medical Reason

Social History:

Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on_____(approx. date)
☐ Current Smoker → Started_____(approx. date) Amount of cigarettes:_____per day
☐ Use tobacco in other forms →_____Amount:_____per day

Alcohol Use History: Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES
If Yes: → How often? ☐ monthly or less_____drinks per month_____drinks per week_____drinks per day
How often >6 drinks on one occasion in past year? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐Daily

Allergies and Your Allergic Response: or ☐ *No Known Allergies*

_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____
_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

☐ *None*

#	Medication Name	Dose	Frequency	Route
1				☐Oral ☐
2				☐Oral ☐
3				☐Oral ☐
4				☐Oral ☐
5				☐Oral ☐
6				☐Oral ☐
7				☐Oral ☐

Patient Signature:_____ **Date:**_____

OFFICE USE ONLY

Blood Pressure:_____/_____ **R L** **MRN:**_____

Staff Signature:_____ **Date:** _____

Patient Education from Healthwise: ☐*Tobacco Cessation <24 months* ☐*Hypertension >140/90 or pre-hypertension 120/80 to 139/89*

Provider Signature:_____**Date:**_____

*Diagnosis Code(s) from Encounter Form: (1) Primary:*_____*Others:*_____