VEIN THERAPY QUESTIONNAIRE

**** PLEASE PRINT **** Appt Date: _____

Name: _____ Med # _____
Address: _____ Apt # _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Wk Phone: ( ) _____ Cell: ( ) _____
Social Security # _____ Date of Birth: _____
Referring or Primary Physician: _____
Where did you hear about this procedure? _____

PLEASE CHECK ALL THAT APPLY TO YOU

Are you seeking treatment for:
Cosmetic Reasons (for appearance): Yes _____ No _____
Medical Reasons (pain, swelling, cramping) Yes _____ No _____

Do you have a history of:

Phlebitis	Yes _____ No _____	Rt leg _____ Lt Leg _____
Blood Clots (DVT)	Yes _____ No _____	Rt leg _____ Lt Leg _____
Pulmonary Embolism	Yes _____ No _____	Rt leg _____ Lt Leg _____
Leg Ulcers	Yes _____ No _____	Rt leg _____ Lt Leg _____

What are we seeing you for today?

Pain in leg	Rt _____ Lt leg _____
Swelling in leg	Rt _____ Lt leg _____
Heaviness	Rt _____ Lt leg _____
Itching	Rt _____ Lt leg _____
Bleeding	Rt _____ Lt leg _____
Skin Ulcers	Rt _____ Lt leg _____

Have you ever had treatment with:

Support Stockings	Yes _____ No _____
Sclerotherapy	Yes _____ No _____
Laser therapy	Yes _____ No _____
Surgery (stripping)	Yes _____ No _____

Any family history of Varicose Veins? Yes _____ No _____ Who? _____

Location of Pain: Thigh _____ Calf _____ Knee _____ Ankle _____
What Type of Pain: Burning _____ Aching _____ Stabbing _____ Throbbing _____ Cramping ____
Pain Scale 1-10 (1 = no pain, 10 = severe pain): _____ How many times a week? _____
How Long: 6 months _____ 1 year _____ More than 1 year _____
What factors aggravate the pain or relieve the pain? _____

Personal History

Are you a smoker? Yes _____ No _____ If yes, for how many years have you been smoking? _____
How many packs do you smoke a day? _____
If you quit smoking, how long did you smoke and when did you quit? _____

Do you drink alcohol? Yes _____ No _____ If so, how many drinks per day? _____

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Medical History

Do you have a history of:

Headaches/Migraines	Yes _____ No _____	Diabetes	Yes _____ No _____
Stroke	Yes _____ No _____	HIV	Yes _____ No _____
Seizures	Yes _____ No _____	Abdominal Pain	Yes _____ No _____
Chest Pain	Yes _____ No _____	Bowel disturbances	Yes _____ No _____
Heart Murmur	Yes _____ No _____	Hepatitis	Yes _____ No _____
Shortness of Breath	Yes _____ No _____	Low back pain radiating	
Cough	Yes _____ No _____	Down the legs	Rt _____ Lt _____
High blood pressure	Yes _____ No _____	Pain in Legs or calves	
High Cholesterol	Yes _____ No _____	while walking	Rt _____ Lt _____

Do you take any of the following medications?

Aspirin	Yes _____ No _____
Blood Thinners	Yes _____ No _____
Pain Killers	Yes _____ No _____
Steroids	Yes _____ No _____
Oral contraceptives	Yes _____ No _____
Estrogen or Hormones	Yes _____ No _____
Minocyclines	Yes _____ No _____
Tamoxifen	Yes _____ No _____

Do you have any history of heart disease in the family?

Yourself	Yes _____ No _____
Mother	Yes _____ No _____
Father	Yes _____ No _____

Explain _____

List all medications that you take regularly:

_____

_____

List all **Allergies** to any medications (or latex):

_____

_____

List all prior surgeries:

_____

_____

VEIN THERAPY QUESTIONNAIRE

((for office staff))

VITAL SIGNS:

B/P _____ PULSE _____ RESP _____ PEDAL PULSES: R _____ L_____

LUNGS _____ HEART _____

TREATMENT PLAN

_____

_____

_____