HISTORY

Patient Name: ______________________________ **Date of Birth:** ____________

Reason for Visit: ______________________________

Referring Physician: ______________________________ **PCP:** ____________

How did you hear about us? ☐**Internet search** ☐**Magazine Ad** ☐**Television Ad** ☐**Billboard** ☐**Facebook/Instagram** ☐**Referring Physician** ☐**Friend/Relative** ☐**Other**______________________

Do you or any of your immediate family members have any of the following conditions?	Patient	Family	Family member affected
Diabetes	☐ No ☐ Yes	☐ No ☐ Yes	
Peripheral Arterial Disease (PAD)	☐ No ☐ Yes	☐ No ☐ Yes	
Have you ever had a stroke?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you ever been told you had an aortic aneurysm (AAA)?	☐ No ☐ Yes	☐ No ☐ Yes	
Heart disease?	☐ No ☐ Yes	☐ No ☐ Yes	
High Cholesterol?	☐ No ☐ Yes	☐ No ☐ Yes	
Lung Disease?	☐ No ☐ Yes	☐ No ☐ Yes	
Kidney Disease?	☐ No ☐ Yes	☐ No ☐ Yes	
High Blood Pressure?	☐ No ☐ Yes	☐ No ☐ Yes	
Bleeding Tendencies?	☐ No ☐ Yes	☐ No ☐ Yes	
Cancer? Type:____________	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have sores/ulcers on your feet or ankles?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have varicose veins?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you had blood clots in your legs?	☐ No ☐ Yes	☐ No ☐ Yes	
Have you been told you have a blood disorder?	☐ No ☐ Yes	☐ No ☐ Yes	
Do you have difficulty walking?	☐ No ☐ Yes		
How far can you walk? ☐ around the house ☐ ½ block ☐ 1 block ☐ 2 blocks ☐ ½ mile or more			
Do you walk: ☐ independently ☐ with a cane ☐ with crutches ☐ with a walker ☐ I use a wheelchair			

Please list your previous surgeries and their approximate dates: (attach additional sheet if necessary)

____

____

Have you ever had a colonoscopy or other colon surgery? ______________________________

This section is for Vein Patients only:

Please indicate previous vein procedures you have had and the approximate date:

Stab Phlebectomy ☐ No ☐ Yes Date: __________ Performing Physician: __________

Venous Ligation with Stripping ☐ No ☐ Yes Date: __________ Performing Physician: __________

Endovenous Laser Ablation ☐ No ☐ Yes Date: __________ Performing Physician: __________

Radiofrequency Ablation (VNUS) ☐ No ☐ Yes Date: __________ Performing Physician: __________

Sclerotherapy ☐ No ☐ Yes Date: __________ Performing Physician: __________

Have you worn Compression Stockings ☐ No ☐ Yes If yes, how many months have you consistently worn them? __________

Do you take any medications to relieve leg pain? ☐ No ☐ Yes if yes, how often do you take it? __________

Do you currently have:	Right	Left
-pain in your thigh, calf, or foot?	☐	☐
-ulcers or sores on your ankle?	☐	☐
-bleeding from veins?	☐	☐
-swelling?	☐	☐
-other skin changes?	☐	☐

The leg pain is worse with…	**Yes**	**No**
-standing	☐	☐
-heat	☐	☐
-before menses	☐	☐

The leg pain is better with…	**Yes**	**No**
-elevation of the leg	☐	☐
-compression hose	☐	☐
-medication	☐	☐
-exercise/walking	☐	☐

Your pain feels like…		
-an ache/tiredness/heaviness	☐	☐
-a cramp	☐	☐
-a burning or itching sensation	☐	☐
-numbness	☐	☐

Current Medications: (attach additional sheet if necessary) **Dosage (mg)** **How often each day**

Medication	Dosage (mg)	How often each day

Please list your known drug, food and environmental allergies: ______________________________

____

Do you take any of these blood thinners? **Coumadin Warfarin ASPRIN Plavix other** ________________
If yes, how often and what dosage?______________________________

Do you **Dialyze**? ☐ No ☐ Yes If yes, what days do you dialyze? TTS ☐ MWF ☐
Name of Dialysis Center______________________________

Do you use alcohol? ☐ No ☐ Occasionally ☐ Daily Are you a recovering alcoholic: ☐ No ☐ Yes
Do you smoke? ☐ No
☐ Yes: list the # of packs you smoke per day: _______ # of years have you smoked? ______
☐ Recently quit, date quit:________________
Do you use recreational drugs? ☐ No ☐ Yes

What is your occupation? ______________________________
Does your job require any of the following: prolonged standing ☐ No ☐ Yes
prolonged sitting ☐ No ☐ Yes

Do you exercise? ☐ regularly ☐ rarely ☐ not at all
Please list types of exercise ______________________________

For Female Patients: Are you currently pregnant? ☐ No ☐ Yes
# of previous pregnancies ___________ # of children ___________
Are you currently taking birth control? ☐ No ☐ Yes
Are you currently taking female Hormones? ☐ No ☐ Yes
Have you had a tubal ligation? ☐ No ☐ Yes
Have you had a hysterectomy? ☐ No ☐ Yes

Are you currently experiencing any of the following?

General Information:
Stress? ☐ No ☐ Yes
Recent weight change? ☐ No ☐ Yes
Loss - # of lbs. ________
Gain - # of lbs. ________
Fever? ☐ No ☐ Yes
Fatigue? ☐ No ☐ Yes
Insomnia? ☐ No ☐ Yes

Eyes:
Blurred or double vision? ☐ No ☐ Yes
Glaucoma? ☐ No ☐ Yes
Blindness (temp/perm)? ☐ No ☐ Yes

Ears/Nose/Throat:
Hearing Loss? ☐ No ☐ Yes
Ringing? ☐ No ☐ Yes
Nosebleeds? ☐ No ☐ Yes

Cardiovascular:
Ever had heart attack? ☐ No ☐ Yes
Ever have heart failure? ☐ No ☐ Yes
Palpitations? ☐ No ☐ Yes

Cardiovascular:
Irregular / fast heartbeat? ☐ No ☐ Yes
Chest pain? ☐ No ☐ Yes
Heart murmurs? ☐ No ☐ Yes

Respiratory:
Coughing up Blood? ☐ No ☐ Yes
Chronic or frequent coughing? ☐ No ☐ Yes
Shortness of breath? ☐ No ☐ Yes
Asthma? ☐ No ☐ Yes
Wheezing? ☐ No ☐ Yes

Neurological:
Frequent or recurring headaches? ☐ No ☐ Yes
Light headed or dizziness? ☐ No ☐ Yes
Seizures? ☐ No ☐ Yes
Paralysis? ☐ No ☐ Yes
Change in speech? ☐ No ☐ Yes
Weakness in arms/legs? ☐ No ☐ Yes
Numbness in arms/legs? ☐ No ☐ Yes

Psychiatric:

Memory loss / confusion?	☐ No	☐ Yes
Depression?	☐ No	☐ Yes
Nervousness?	☐ No	☐ Yes

Endocrine:

Hormone Problems?	☐ No	☐ Yes
Excessive thirst or urination?	☐ No	☐ Yes
Heat / cold intolerance?	☐ No	☐ Yes

Musculoskeletal:

Arthritis?	☐ No	☐ Yes
Lower Back Pain?	☐ No	☐ Yes
Joint pain?	☐ No	☐ Yes
Swelling of legs, feet or ankles?	☐ No	☐ Yes
Leg Injury?	☐ No	☐ Yes
Cold feet or hands?	☐ No	☐ Yes

Hematological / Lymphatic:

Slow to heal after cuts?	☐ No	☐ Yes
Anemia?	☐ No	☐ Yes
Easy bleeding?	☐ No	☐ Yes
Easy bruising?	☐ No	☐ Yes

Allergy / Immunologic:

Hepatitis?	☐ No	☐ Yes
HIV / AIDS	☐ No	☐ Yes

Gastrointestinal:

Loss in appetite?	☐ No	☐ Yes
Change in bowel habits?	☐ No	☐ Yes
Abdominal pain?	☐ No	☐ Yes
Hernia?	☐ No	☐ Yes

Type of hernia ________________

Stomach ulcers?	☐ No	☐ Yes
Nausea / Vomiting?	☐ No	☐ Yes

Integumentary:

Rash?	☐ No	☐ Yes
Itching?	☐ No	☐ Yes
Change in skin / hair / nails?	☐ No	☐ Yes
Yellow Jaundice?	☐ No	☐ Yes
Phlebitis?	☐ No	☐ Yes

Genitourinary:

Frequent Urination?	☐ No	☐ Yes
Painful / Burning urination?	☐ No	☐ Yes
Bladder control problems?	☐ No	☐ Yes

Males Only:

Prostate problems?	☐ No	☐ Yes
Impotence?	☐ No	☐ Yes

Patient's signature: ________________________________

Today's DATE: ________________________________