A center exclusively for the treatment of varicose and spider veins

Lori L. Greenwald, MD, FACS
Medical Director

Name: _____ DOB: _____

Date: _____ **Patient History Form**

Age: _____ Sex: M _____ F_____

Referred by: (please tell us their name)_____Newspaper_____ Internet_____

Ad (where)_____Friend_____Other(please specify)_____

Primary Care Physician (PCP):_____PCP Phone:_____

Please complete the following questionnaire, trying not to leave any blank spaces. The more information we have, the better we can care for you.

Reason for consultation: Right leg_____ Left leg_____ Both_____

Vascular History

How old were you when you first noticed your varicose veins? _____

Do you have or have you ever been diagnosed with any of the following?

Varicose vein problems	Yes	No	R___ L___
Phlebitis (redness/tenderness of vein)	Yes	No	R___ L___
Blood clots	Yes	No	R___ L___
Deep vein thrombosis (DVT)	Yes	No	R___ L___
Saphenous vein reflux	Yes	No	R___ L___

Please Explain:

_____

Do you experience any of the following in your leg(s)?

Aching	Yes	No	R___ L___
Throbbing	Yes	No	R___ L___
Pain (sharp/stabbing)	Yes	No	R___ L___
Heaviness	Yes	No	R___ L___
Tiredness/fatigue	Yes	No	R___ L___
Itching	Yes	No	R___ L___
Burning	Yes	No	R___ L___
Ankle Swelling	Yes	No	R___ L___
Vein swelling	Yes	No	R___ L___
Restless legs	Yes	No	R___ L___
Night cramps	Yes	No	R___ L___
Skin discoloration	Yes	No	R___ L___
Ulcers	Yes	No	R___ L___
Bleeding varicosities	Yes	No	R___ L___
Have your veins gotten worse in recent months?	Yes	No	R___ L___

Height _____ **Weight**_____

Are your symptoms worse with any of the following?

Prolonged sitting	Yes	No
Prolonged standing	Yes	No
Walking	Yes	No
Climbing stairs	Yes	No
Exercise	Yes	No
Heat	Yes	No

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Which of the following do you do to treat your leg symptoms:

Medication	Yes No	Name:_____	How often ?
Elevation of the legs	Yes No	How long:_____	and how any times a day?
Wear support hose	Yes No	Type:_____	for how long

Which of the above treatments help? _____

Have you seen any physician in the past for your varicose veins?
Please provide any documentation of past symptomatic treatments? (i.e. prescription for compression hose, PCP office notes, ObGYN notes, etc.)

Vein Treatment History

Have you ever been treated for varicose veins with the following: By Whom?_____

Sclerotherapy (varicose/spider vein injections)	Yes	No	R___ L___	Date:_____
Laser therapy	Yes	No	R___ L___	Date:_____
Phlebectomy	Yes	No	R___ L___	Date:_____
Vein stripping surgery	Yes	No	R___ L___	Date:_____
Vein Ablation Procedure	Yes	No	R___ L___	Date:_____
Compression stockings	Yes	No	R___ L___	Date:_____

WOMEN ONLY (Please answer the following):

1. Is there a chance you are currently pregnant?	Yes	No	N/A
2. # of pregnancies: _____ # of children: _____ ages: _____			
3. Have your veins gotten worse with pregnancy?	Yes	No	
4. Are you currently breast feeding?	Yes	No	N/A
5. Are your symptoms worse with menses?	Yes	No	N/A
6. Are your symptoms worse with menopause?	Yes	No	N/A
7. Do you take birth control pills?	Yes	No	N/A
8. Do you use hormone replacement therapy?	Yes	No	N/A

Past Medical History (Please circle the appropriate answer)

1. Previous Hospitalizations Yes No
If yes, reason for hospitalization._____
_____

2. Surgeries? Yes No
If yes, what type of surgery and when? _____
_____

3. Are you presently under the care of a physician? Yes No
If yes, please explain._____
_____
_____
_____

Past Medical History Do you have a history of any of the following?

Heart disease/heart attack/stress test	Yes	No	Cancer	Yes	No	
Mitral valve prolapse	Yes	No	Thyroid	Yes	No	
High blood pressure	Yes	No	Fear of Needles	Yes	No	
Elevated cholesterol	Yes	No	History of fainting	Yes	No	
Lung disease/asthma/bronchitis/emphysema	Yes	No	Blood Disorder	Yes	No	
Tuberculosis (TB)	Yes	No	Clotting/Bleeding Disorder	Yes	No	
Diabetes	Yes	No	Anemia	Yes	No	
Liver disease/hepatitis	Yes	No	HIV/AIDS	Yes	No	
Kidney disease	Yes	No	Blood Transfusions	Yes	No	
Osteoporosis	Yes	No	Tattoos	Yes	No	
Asthma	Yes	No	Migraines and or Ocular Migraines	Yes	No	Explain_____
Lactose Intolerant	Yes	No				

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Review Of Symptoms **Do you ever experience any of the following?**

Chest pain	Yes	No	Knee/Hip pain	Yes	No
Shortness of breath	Yes	No	Back Pain	Yes	No
Palpitations	Yes	No	Keloid/Excessive scarring	Yes	No
Irregular heart beat	Yes	No	Sudden weight loss or gain	Yes	No
Low blood pressure	Yes	No	Visual Problems	Yes	No
Seizures	Yes	No	Depression/Memory Loss	Yes	No

If you have answered yes to any of the above, please explain:

_____

_____

Are you currently under a physician's care for any of the above? Yes No

If yes, please explain._____

_____

_____

Family History

Do any of your family members have the following?

Varicose veins	Yes	No	Who?_____
Vein stripping	Yes	No	_____
Blood clots/pulmonary embolism	Yes	No	_____
Blood coagulation disorder	Yes	No	_____
Heart disease/heart attack	Yes	No	_____
Stroke	Yes	No	_____

Social History

Do you exercise regularly?	Yes	No	
Type of exercise: _____			
Do you smoke?	Yes	No	Amount:_____
Do you drink alcohol?	Yes	No	Amount: _____
Do you lift heavy objects?	Yes	No	Weight:_____
Occupation: _____			
Does your work require any of the following:	Yes	No	
Prolonged standing periods	Yes	No	
Prolonged sitting periods	Yes	No	
Lifting more than 15 pounds on a regular basis	Yes	No	

Medications :

(Please list all types including herbals, vitamin K, and over the counter medications)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Name: _____ DOB: _____

Allergy History:
No known allergies ☐
Medication Allergies: Other Allergies: (foods, etc.)

Name:_____ Reaction:_____ _____ Reaction:_____
_____ _____ _____ _____

Do you have any problems with **LATEX**? Yes_____No____

If yes, please explain._____
_____

Do you have any problems with **Local Anesthesia**? Yes____No____
If yes, please explain._____

Is there any other information you feel would be important for us to know?

MD/PA-C SECTION

History reviewed with the patient at the time of the consultation.

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