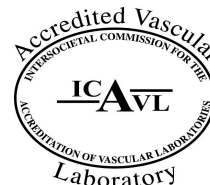




A center exclusively for the treatment of varicose and spider veins



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__

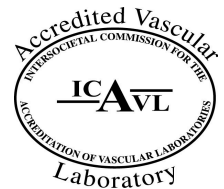
Height _____ **Weight** _____

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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Name: _____ DOB: _____

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 many 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)

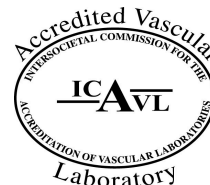
1. Previous Hospitalizations Yes No
If yes, reason for hospitalization. _____
2. Surgeries? Yes No
If yes, what type of surgery and when? _____
3. Are you presently under the care of a physician? Yes No
If yes, please explain. _____

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
Lactose Intolerant	Yes	No			Explain _____



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Name: _____ DOB: _____

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

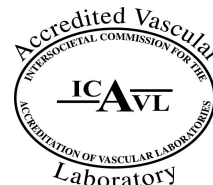
Lifting more than 15 pounds on a regular basis Yes No

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.