A center exclusively for the treatment of varicose and spider veins

Lori L. Greenwald, MD, FACS
Medical Director

Patient History Form

Date: ___________________________

Name: ___________________________________ DOB: _________________________

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?

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

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.____

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.____

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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)

_________________ _________________ _________________

_________________ _________________ _________________

_________________ _________________ _________________

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?

____

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Name:______________________________ DOB:________________

DR. LORI GREENWALD, MD FACS DABVLM

CIVIQ Venous Quality of Life Questionnaire

Many people in the country complain of heavy, aching or tired legs. You will find that a certain number of symptoms, sensations, or discomforts that you feel can make everyday life more or less difficult. We are trying to find the **frequency** of your leg problems, and how they can affect your everyday life. *This will help significantly with insurance authorization.*

Please indicate whether you have experienced what is described in the sentence, and if so, to what intensity. Five answers are provided, please circle the intensity most suited to your situation. 1 for being least affected by this, and 5 being the most affected by this.

For each of symptom, sensation, or discomfort listed, we ask you to answer the corresponding question:

In the past 4 weeks, what was the intensity of pain in your ankles and legs?

1- **No pain**
2- **Light pain**
3- **Moderate pain**
4- **Strong pain**
5- **Intense pain**

In the past 4 weeks, to what extent did you feel bothered or limited to daily activities and/or work due to your leg pain?

1- **Not bothered/limited**
2- **A little bothered/limited**
3- **Moderately bothered/limited**
4- **Strongly bothered/limited**
5- **Extremely bothered/limited**

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In the past 4 weeks, how often did you experience a bad night's sleep due to your leg pain?

1- **Never**
2- **Seldom**
3- **Fairly often**
4- **Very often**
5- **Every night**

During the past four weeks, to what extent did your leg problems bother/limit you while doing the movements or activities listed below? *(For each of the questions listed in the left hand column of the table below, indicate to what extent you are bothered/limited by circling the corresponding number).*

	Not bothered/ limited at all	***A little bothered/ limited***	***Moderately bothered/ limited***	***Very bothered/ limited***	***Extremely bothered/ limited***
To stand for a long time					
To climb stairs					
To crouch, to kneel					
To walk briskly					
To travel by car, bus, or plane					
To do housework (cleaning, cooking, small handy work)					
To go to weddings, parties, cocktail hour					
To do a sport, physically strenuous efforts					

Leg problems can also have an effect on one's morale. To what extent do the following sentences correspond to the way you have felt during the past four weeks? *(For each of the sentences listed in the left hand column of the table below, circle the number that best corresponds to the right answer).*

	Not at all	***A little***	***Moderately***	***A lot***	***Absolutely***
I feel on edge					

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I become tired quickly					
I feel like I am a burden to people					
I must always take precautions such as stretching my legs for an extended period of time					
I am embarrassed to show my legs					
I get irritated easily					
I feel handicapped					
I have difficulty to get going in the morning					
I do not feel like going out					