

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_

Today's Date: \_\_\_\_\_

Sex:  M  F Occupation: \_\_\_\_\_ OR  I am Retired

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (GVS ONLY: BP: \_\_\_\_\_ / \_\_\_\_\_)

**What kind of problem are you having?**

- Please describe problem: \_\_\_\_\_  
\_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_
- What treatments have you tried in the past? \_\_\_\_\_
- On a scale of 1-10, with 10 being worst, what is your level of discomfort or concern with this problem? \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN (if different than referring physician): \_\_\_\_\_

**PAST MEDICAL HISTORY: Do you have any of the following conditions: (PLEASE MARK YES OR**

**NO)**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure            | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer, Type: _____              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis, Type: _____           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes, Type: _____            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral Valve Prolapse          | <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or HIV                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Atherosclerosis/artery disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency, Type: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Tendency                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No COPD                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Blood Transfusion       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Anesthesia Problem      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Valley Fever                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____                     |

**PAST SURGICAL HISTORY: Please indicate past surgeries or serious illnesses with approximate date:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYSTEMS: Do you have any problems or symptoms in the following areas? Please describe.**

**Neurological:** Head, brain, or sensory (fainting, unconsciousness, numbness, weakness, headaches, seizures, tremors) \_\_\_\_\_ OR  No known neurological conditions

**Cardiovascular:** Heart, vessels, arteries or anemia (chest pain, heart murmur, heart disease): \_\_\_\_\_ OR  No known cardiovascular conditions

**Respiratory/Lungs:** (breathing difficulties, coughing, hoarseness): \_\_\_\_\_ OR  No known respiratory conditions

**Skin:** (easy bruising, change in texture, infections, boils, cysts, masses): \_\_\_\_\_ OR  No known skin conditions

**Gastrointestinal:** (heartburn, stomach ulcer, colon cancer, bleeding, polyps, family history): \_\_\_\_\_ OR  No known gastrointestinal conditions

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**Kidneys/Bladder:** (blood in urine, infections, reproductive organs): \_\_\_\_\_  
\_\_\_\_\_ OR \_\_\_ No known genitourinary conditions

**Muscles/Extremities:** (fractures, blood clots, varicose veins, injury): \_\_\_\_\_  
\_\_\_\_\_ OR \_\_\_ No known musculoskeletal conditions

**Rectal:** (hemorrhoids, bleeding, pain): \_\_\_\_\_  
\_\_\_\_\_ OR \_\_\_ No known rectal conditions

**Varicose Veins:** Have you had any of the following? \_\_\_\_\_ or \_\_\_ No known varicose veins

- Leg Pain (indicate: RIGHT LEFT BOTH)
- Leg Swelling (indicate: RIGHT LEFT BOTH)
- Leg ulcers (indicate: RIGHT LEFT BOTH)
- Previous vein therapy (indicate type and leg performed on) \_\_\_\_\_

- "Spider" veins (indicate: RIGHT LEFT BOTH)

**What have you tried to relieve the symptoms?**

- Prescription Compressive Stockings (indicate how long you have worn) \_\_\_\_\_
- Leg elevation \_\_\_Yes \_\_\_No
- Exercise (indicate type) \_\_\_\_\_
- Change in diet (indicate changes) \_\_\_\_\_
- Non-steroidal anti-inflammatories such as Aleve, Ibuprofen, Advil: \_\_\_Yes \_\_\_No

What is your primary concern about your varicose veins? \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? \_\_\_Yes \_\_\_No What tobacco product/ how much per day/ for how long? \_\_\_\_\_

OR \_\_\_ I quit \_\_\_\_\_ ago

Do you drink? \_\_\_Yes \_\_\_No What alcohol product/ How much/ what frequency/for how long? \_\_\_\_\_

OR \_\_\_ I quit \_\_\_\_\_ ago

Do you use illicit drugs? \_\_\_Yes \_\_\_No Which substance/ how frequently? \_\_\_\_\_

OR \_\_\_ I quit using \_\_\_\_\_ (substance) \_\_\_\_\_ (how long) ago

**CURRENT MEDICATIONS OR HERBAL PRODUCT Please list all current medications or herbal products/dosages/frequency/for what condition or provide a list:**

\_\_\_ I take no medications or herbal products

\_\_\_ See attached list

Medication or Herb Name	Dose	How Often	For what condition?
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			
8) _____			

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- Current or previous steroid use?  Yes  No What kind/how long/when? \_\_\_\_\_
- Current or previous blood thinners?  Yes  No What kind/how long/when? \_\_\_\_\_

**ALLERGIES Are you allergic to any medications?  Yes  No If yes, please list what you are allergic to and what kind of reaction you get with each medication.**

Medication Name	Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____
7) _____	_____
8) _____	_____

- Have you ever had an allergic reaction to shellfish or IVP dye (used in angiograms)?  Yes  No

**FAMILY HISTORY**

I was adopted

Are there any illnesses in your family? (cancer, stroke, heart disease)? \_\_\_\_\_  
\_\_\_\_\_

If so, is relative living or deceased? \_\_\_\_\_  
\_\_\_\_\_

Describe nature of illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have an Advanced Directive?  Yes  No

Do you have a Living Will?  Yes  No

Do you have a Medical Power of Attorney?  Yes  No IF YES, PLEASE PROVIDE OUR OFFICE WITH A COPY

- Name: \_\_\_\_\_
- Relationship: \_\_\_\_\_
- Phone Number: \_\_\_\_\_

Are you enrolled in Hospice?  Yes  No

- If yes, Name of Hospice & Phone Number: \_\_\_\_\_

**➡ Physician's Signature & Date Verifying Review:**