

Patient's Name: _____ DOB: _____ Age _____

Sex: M F Occupation: _____ OR I am Retired

Height: _____ Weight: _____ Place of Birth: _____

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 _____ ago
(substance) (how long)

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

___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

- Name: _____
- Relationship: _____
- Phone Number: _____

Are you enrolled in Hospice? Yes No

- If yes, Name of Hospice & Phone Number: _____