Advanced Vein Center

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Patient Name:	**Age:**
Date of Birth:	

PERSONAL HEALTH HISTORY

What is the reason for your visit today?
☐ Spider Veins ☐ Both
☐ Varicose Veins ☐ Other

When did you first notice this problem?

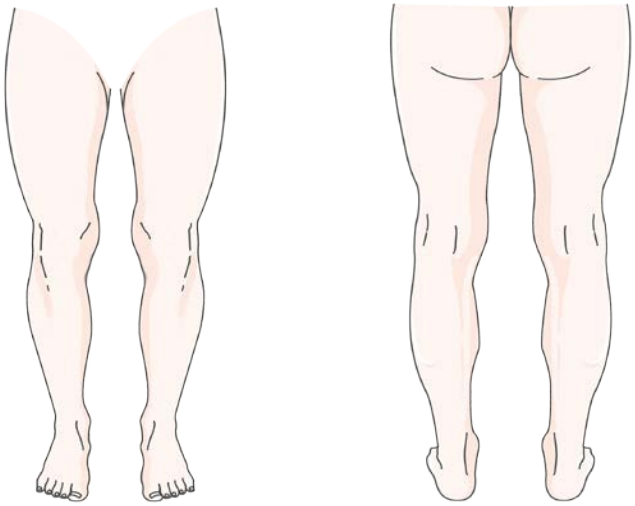
Are you consulting for:
☐ Medical Purposes
☐ Cosmetic Purposes
☐ Both

What would you most like to correct?

Please indicate if you have experienced:

Leg Pain	☐ Right	☐ Left
Leg Heaviness	☐ Right	☐ Left
Leg Fatigue	☐ Right	☐ Left
Ankle or Leg Swelling	☐ Right	☐ Left
Restless Legs	☐ Right	☐ Left
Skin Discoloration around the ankles	☐ Right	☐ Left
Itching	☐ Right	☐ Left
Leg ulceration	☐ Right	☐ Left
Phlebitis	☐ Right	☐ Left
Varicose vein rupture or bleeding	☐ Right	☐ Left
DVT (blood clot)	☐ Right	☐ Left

Please draw or shade the areas of your legs that are bothersome.



When are your symptoms worse?

At the end of the day	☐
Prolonged Standing	☐
Prolonged sitting	☐
During menstruation	☐
During walking	☐
With heat	☐

What brings or has brought relief?

Leg elevation	☐	Hot/ cold packs	☐
Exercise	☐	Weight Loss	☐
Compression stockings	☐	Supplements	☐
Medication	☐		
Other			

Do your symptoms interfere with your lifestyle or ability to work?

What is your occupation?

Does your occupation require long periods of standing or sitting?

Do you presently wear compression stockings?

If yes, when was the earliest date you tried them?

Were they prescribed by a doctor or over-the-counter?

Please List Prior Vein Treatment and Year			
	Sclerotherapy		Foam Sclerotherapy
	Vein Stripping Surgery		Phlebectomy
	EVLA		Laser (for spider veins)
	VNUS Closure		Other:

Please List All Health Conditions / Medical Problems		
Year		

Please List any Surgeries or Major Hospitalizations		
Year		

ALLERGIES

Please describe any allergies you have (include medications, food, detergents, etc.) and the type of reaction you had.

Are you allergic to latex?	☐ Yes	☐ No
Are you allergic to adhesive tapes?	☐ Yes	☐ No
Are you allergic to lidocaine?	☐ Yes	☐ No
Are you allergic or sensitive to iodine?	☐ Yes	☐ No

CURRENT MEDICATIONS		
Are you taking aspirin?	☐ Yes	☐ No
Are you taking plavix, aggrenox, lovenox or coumadin?	☐ Yes	☐ No
Are you taking over the counter blood thinning agents such as vitamin E or gingko biloba?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and supplements

Medication Name	Strength	Frequency Taken

HEALTH HABITS AND SOCIAL HISTORY

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) Please list the type of exercise:			
Tobacco & Alcohol	*Do you use tobacco?*		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ # of years	☐ Or year quit	☐ Cigars - #/day
	Do you drink alcohol?	*If yes, how many drinks per week?*		

FAMILY HEALTH HISTORY

*Is there a **FAMILY** history of spider or varicose veins?*	☐ Yes	☐ No
*Is there a **FAMILY** history of DVT or blood clotting disorders?*	☐ Yes	☐ No
*Is there a **FAMILY** history of leg ulcers related to vein problems?*	☐ Yes	☐ No

WOMEN ONLY		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Number of pregnancies____ Number of live births ____		
Do you have prominent veins in the pelvic or vulva region?	☐ Yes	☐ No
Do you have pelvic pain after long periods of standing or at the end of the day?	☐ Yes	☐ No
Do you have pelvic pain after sex?	☐ Yes	☐ No
Do you have pelvic pain or heaviness with menses?	☐ Yes	☐ No

SYSTEMS REVIEW

Check if you have, or had any symptoms in the following areas to a significant degree and briefly explain.

☐ **CARDIOVASCULAR**	☐ **NEUROLOGICAL**	☐ **HEMATOLOGICAL**
☐ Congestive heart failure	☐ Migraine headaches	☐ Blood clots
☐ Heart Murmur	☐ Epilepsy/Seizures	☐ Easy bruising or bleeding
☐ PAD	☐ TIA or Stroke	☐ Anemia
☐ Chest pain	☐ Fainting	☐ Malignancy: Type
☐ MI (Heart Attack)	☐ Numbness	
☐ Vascular surgery	☐ **DERMATOLOGICAL**	☐ **INFECTIOUS DISEASE**
☐ Heart or bypass surgery	☐ Eczema	☐ HIV +
☐ **PULMONARY**	☐ Skin rash	☐ Hepatitis B/C
☐ Shortness of breath	☐ **ENDOCRINE**	☐ **MUSCULOSKELETAL**
☐ Asthma/wheezing	☐ Diabetes mellitus type I or II	☐ Fibromyalgia
☐ Cough	☐ Thyroid disease	Muscle pain

☐ Indicate if you have had any of the following ***recently:***	☐ Flu-like symptoms	☐ Fatigue or weakness
☐ Unintended weight loss	☐ Nausea	☐ Fever