PATIENT HISTORY

Name:______________________________________

Date of birth:_____________ **Age:**______ **Height:**_____*ft*_____*in* **Weight:**_______*lbs*

Today's date:_____________ **Your appointment time:**________ *am pm* **Clinic location**_____________

What is your communication preference? *(Please select best ONE)*

- ☐ Home phone ☐ May leave voice mail ☐ Text
- ☐ Work phone ☐ May leave voice mail ☐ Text
- ☐ Cell phone ☐ May leave voice mail ☐ Text
- ☐ Email

Preferred primary language:

- ☐ English
- ☐ Other: ________________________

Race:

- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Decline to state

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to state

Symptoms *(Please check if yes)*

	L	R
Aching/pain in legs	☐	☐
Heaviness	☐	☐
Tiredness/fatigue	☐	☐
Itching/burning/warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

- ☐ Do your symptoms interfere with your sleep?
- ☐ Are your symptoms worse later in the day?
- ☐ Are your symptoms worse with or after activity?
- ☐ Do your symptoms keep you from doing anything?

Check if you've had any of the following:

- ☐ Heart Disease
- ☐ HIV
- ☐ High blood pressure
- ☐ Cancer
- ☐ Asthma/COPD
- ☐ Major surgery/hospitalizations
- ☐ Peripheral arterial disease
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Leg trauma/surgery

*Briefly describe:*____

____

____

____

- ☐ Do you have an Advanced Directive?

Tobacco use history

- ☐ Never smoked or used tobacco
- ☐ Quit on: ______________________*(approximate date)*
- ☐ Current tobacco user

Amount:________*cigarettes per day or* ______*cigarettes per week*
or (other) _____________*per day or (other)*_____________*per week*

Restless legs syndrome *(Please check if yes)*

- ☐ Do you find the need to move your leg(s) to relieve an uncomfortable feeling?
- ☐ Are your leg symptoms worse later in the day or night?

Conservative measures used currently or previously: *(Check all that you have tried)*

- ☐ Pain medications
- ☐ Exercise
- ☐ Leg elevation
- ☐ Compression stockings or leg wraps?
  *Strength of stockings:*______________*mmHg*
- ☐ Weight Loss
- ☐ Job Change

Women only: *(Check all that apply)*

- ☐ Are you pregnant or considering a pregnancy sometime in the future?
- ☐ Are you breast feeding?
- ☐ Are your legs more painful associated with menstruation?
- ☐ Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy?

Number of pregnancies____________________________

Number of deliveries_____________________________

Number of miscarriages____________________________

Children's ages__________________________________

Provider reviewed with patient:____**Date:**_______________

Name:____ **Date of birth:**______________

Please check below if you have, or have had, any of the following:

- ☐ A prior evaluation of your veins ________*yr*
- ☐ Previous vein surgery or laser treatments ________*yr* *R L*
- ☐ Previous vein injections ________*yr* *R L*
- ☐ A leg ulceration ________*yr* *R L*
- ☐ Bleeding from a vein ________*yr* *R L*
- ☐ Superficial thrombophlebitis or ________*yr* *R L*
  an inflammation of a vein________________________________*location*
- ☐ Any type of blood clot ________________________________*location*
- ☐ Any type of clotting disorder ___________________________*diagnosis*
- ☐ Diagnosed with a PFO (patent foramen ovale)
- ☐ A family history of vein disease
- ☐ A family history of blood clots
- ☐ A family history of a clotting disorder

Do you have any Peripheral Arterial Disease (PAD) symptoms?

(Check all that apply)

- ☐ Was diagnosed with PAD in the past
- ☐ Have/had cramping leg pain that
worsens with walking, forcing me to stop walking
- ☐ Have/had ulcers on feet or toes

Allergies

☐ No known allergies

Allergy	*Your Allergic Response*					
_________________	☐ Rash	☐ Nausea/Vomiting	☐ Diarrhea	☐ Shortness of breath	☐ Anaphylaxis	☐ Other______________
_________________	☐ Rash	☐ Nausea/Vomiting	☐ Diarrhea	☐ Shortness of breath	☐ Anaphylaxis	☐ Other______________
_________________	☐ Rash	☐ Nausea/Vomiting	☐ Diarrhea	☐ Shortness of breath	☐ Anaphylaxis	☐ Other______________
_________________	☐ Rash	☐ Nausea/Vomiting	☐ Diarrhea	☐ Shortness of breath	☐ Anaphylaxis	☐ Other______________

Current medications *Include prescription drugs, over-the-counter drugs, vitamins, minerals, herbals, and dietary (nutritional) supplements* ☐ None

Medication Name	Dose	Frequency	Route *(oral or other)*

Patient Signature:____Date:______________

OFFICE USE ONLY

Blood pressure:_________________/________________ **R L** **MRN:**____________________________

Staff signature:____ **Date:**____________________________

Physician signature:____________________________________ **Date:**____________________________