VeinSolutions™
Leaders in Cosmetic & Therapeutic Vein Care

HISTORY AND PHYSICAL CONSULTATION FORM

Date: _____ Patient Name: _____ DOB: _____

Sex: M / F (*circle one*) **Ht: _____ft:_____in Wt: _____ lbs BP:_____ / _____ Pulse:_____bpm**

Reason for today's visit: _____

_____

Medication ALLERGIES: *OR* ❑ **NONE (***no allergies)*

Medication	Reaction you have
1.	
2.	
3.	

MEDICATIONS you currently take: *OR* ❑ **NONE (***check box if you take no meds)*

Medication	Dose	How often
1.		
2.		
3.		
4.		
5.		
6.		

PAST MEDICAL HISTORY: *(CIRCLE THE CONDITIONS BELOW THAT APPLY TO YOU)*

Aneurysm: abdominal, thoracic (chest), cerebral (brain), peripheral (legs)	**Genitourinary Disease:** urinary frequency, incontinence, prostate problems
Autoimmune Disorder: lupus, MS, rheumatic fever, Sjogren's syndrome	**Heart Valve Disease:** aortic, mitral, tricuspid
Blood Thinners: Coumadin, Plavix, Aspirin, Xarelto, Pradaxa, Fish Oil	**Hematologic Disease:** anemia, clotting disorder, bleeding disorder
Cancer: what type? _____	**Hyperlidemia** (high cholesterol)
Cardiac Arrhythmias: A-fib, PVC	**Hypertension** (high blood pressure)
Carotid Stenosis	**Kidney Disease**: renal cysts, renal transplant
Congenital Heart Disease: ASD, VSD, AVSD, Marfan's, bicuspid valve	**Liver Disease:** jaundice, hepatitis, cirrhosis
Coronary Artery Disease: heart attack (MI), chest pain	**Musculoskeletal:** arthritis, osteoporosis, back pain
Dermatology: shingles, psoriasis	**Neurologic Disorder:** schizophrenia, bipolar disorder, epilepsy
Diabetes: Type 1 Insulin-Dependent, Type 2 Non-Insulin Dependent	**Pacemaker**
ENT: Ears, Nose, Throat problems	**Peripheral Vascular Disease:** DVT, claudication
End Stage Renal Disease (kidney failure)	**Pulmonary/Respiratory Disease:** asthma, COPD, TB
Endocrine problems: thyroid- high / low, parathyroid- high / low, adrenal gland, pituitary	**Sleep Disorder:** insomnia, sleep apnea, narcoleps
Eye Problems: glasses, cataracts, glaucoma, etc	**Other #1:** _____
Gastrointestinal Disease: ulcers, Crohn's, diverticulitis, gallstones, IBS, reflux/heartburn	**Other #2:** _____

SURGICAL HISTORY: **(***Please list all prior surgeries and dates*)

DATE	SURGERY

SOCIAL HISTORY:

Smoking Status:
❑Never smoked ❑Former smoker ❑Current smoker *daily* ❑Current smoker *occasionally*

Number of years you have used tobacco (**even if you quit**): _____

How much do you (or did you) smoke?❑1 pack per day ❑2 packs per day ❑1 pack per week ❑Other: _____

Alcohol Intake: ❑None ❑Occasional ❑Moderate ❑Heavy

Illicit Drugs: ❑None ❑Yes: (what and how often?) _____

Exercise Level: ❑None ❑Occasional ❑Moderate ❑Heavy

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Domestic Partner

FAMILY MEDICAL HISTORY: *OR* ❑ **None/Unknown**

	Mother ✓	**Father** ✓	**Sister** ✓	**Brother** ✓
Aneurysm				
Heart Attack (MI)				
Bleeding				
Blood Clots (DVT)				
Cancer (List type of Cancer)				
Congenital Heart Disease				
Diabetes				
Heart Failure				
Hypertension				
Hyperlipidemia				
Kidney Failure				
Obesity				
Rheumatic Fever				
Stroke				

PROVIDERS:

- Pharmacy / Location: _____

- Primary Care Doctor or Clinic / Phone #: _____

- Referring Doctor / Phone #: _____

- Other Doctors (*pulmonologist, oncologist, cardiologist, etc*.) / Phone #: _____

_____

Dialysis Unit / Days you dialyze (if applicable):_____

Dialysis Unit / Days you dialyze *(if applicable):* **VeinSolutions - Review Of Systems (ROS)**

(please check all the following conditions listed below that you are currently experiencing. If applicable, provide additional notes about the condition)

Patient Name_____ **Patient D.O.B.**_____ **Date**_____ **Athena #** _____ **(for staff only)**

Constitutional	☐**NONE or:** ☐fever ☐night sweats ☐significant weight gain ☐significant weight loss ☐exercise intolerance Additional Notes:_____
Eyes	☐**NONE or:** ☐dry eyes ☐eye irritation ☐vision changes ☐needs glasses/contacts Additional Notes:_____
Ears	☐**NONE or:** ☐difficulty hearing ☐ear pain Additional Notes:_____
Nose	☐**NONE or:** ☐frequent nosebleeds ☐sinus problems ☐nose problems Additional Notes:_____
Mouth/Throat	☐**NONE or:** ☐sore throat ☐bleeding gums ☐snoring ☐dry mouth ☐mouth ulcers ☐oral abnormalities ☐teeth problems Additional Notes:_____
Cardiovascular	☐**NONE or:** ☐chest pain ☐arm pain on exertion ☐shortness of breath when walking ☐shortness of breath when lying down ☐palpitations ☐heart murmur ☐chest pain on exertion ☐light-headed upon standing Additional Notes:_____
Respiratory	☐**NONE or:** ☐cough ☐wheezing ☐shortness of breath ☐coughing up blood ☐sleep apnea Additional Notes:_____
Gastrointestinal	☐**NONE or:** ☐abdominal pain ☐vomiting ☐abnormal appetite ☐diarrhea ☐vomiting blood ☐change in appetite ☐black or tarry stools Additional Notes:_____
Genitourinary	☐**NONE or:** ☐difficulty urinating ☐increased frequency of urination ☐blood in urine ☐loss of bladder control ☐incomplete emptying of bladder ☐decrease of urinary output Additional Notes: _____
Musculoskeletal	☐**NONE or:** ☐muscle aches ☐muscle weakness ☐joint pain ☐back pain ☐swelling in the extremities ☐needs wheelchair ☐needs walker Additional Notes:_____
Neurologic	☐**NONE or:** ☐loss of consciousness ☐weakness ☐numbness ☐seizures ☐dizziness ☐headaches ☐frequent/severe headaches ☐migraines ☐restless legs A ddditional Notes:_____
Endocrine	☐**NONE or:** ☐fatigue ☐increased thirst ☐hair loss ☐increased hair growth ☐cold intolerance Additional Notes:_____
Hematologic/ Lymphatic	☐**NONE or:** ☐swollen glands ☐bruising ☐excessive bleeding Additional Notes:_____
Allergic/ Immunologic	☐**NONE or:** ☐runny nose ☐sinus pressure ☐itching ☐hives ☐frequent sneezing Additional Notes:_____

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REASON FOR VISIT:

❑ Varicose veins / legs ❑ Spider veins / legs ❑ Spider veins / face ❑ Vascular birthmark

❑ Other _____

If you have varicose or spider veins / legs, when did they occur? At age_____

Have you ever been treated for the above problem(s)? ❑ Yes ❑ No

If yes, by whom?_____

When?_____What method? ❑ Sclerotherapy ❑ Laser ❑ Surgery

Have you ever worn support hose? ❑Yes ❑ No Do you currently wear support hose? ❑ Yes ❑ No

Length of time support hose worn _____

Do you use medications to relieve your leg pain? ❑ Yes ❑ No

If yes, list medication _____

FOR VARICOSE & SPIDER VEINS OF THE LEGS COMPLETE THIS SECTION:

	RT LEG	LT LEG		RT LEG	LT LEG
Do you now have:			**The leg pain is better with:**		
Pain in your leg(s)	❑	❑	elevation of the leg(s)	❑	❑
Swelling in your leg(s)	❑	❑	compression hose	❑	❑
Ulcer on your leg(s)	❑	❑	medication	❑	❑
Fatigue in your leg(s)	❑	❑	exercise/walking	❑	❑
The pain is made worse with:			**Your pain feels like:**		
Standing	❑	❑	ache/tiredness/heaviness	❑	❑
Heat	❑	❑	cramp	❑	❑
Before menses	❑	❑	burning	❑	❑
Numbness	❑	❑			

Do your symptoms, caused by your varicose veins and/or spider veins, interfere with your work?

❑ Yes ❑ No COMMENTS _____

VENOUS HISTORY:

Please check if you have a history of:
❑ Phlebitis ❑ Leg ulcers ❑ Pulmonary embolus ❑ Use of anticoagulants (Heparin/Coumadin/Lovenox)

❑ Blood clots ❑ Leg injury ❑ Leg bone fracture ❑ Family history of varicose/spider veins

ACTIVITY: Occupation _____ Do you exercise regularly? ❑ Yes ❑ No
Type of exercise _____
Average time sitting _____% Average time standing _____%

FOR FEMALE PATIENTS:
Are you pregnant: ❑ Yes ❑ No ❑ Unsure Date of last menstrual period _____

pregnancies _____ # of children _____ Are you currently breastfeeding? ❑ Yes ❑ No

Are you taking birth control pills or other hormones? ❑ Yes ❑ No