



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): _____

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)

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



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)	<input type="checkbox"/>	<input type="checkbox"/>	elevation of the leg(s)	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in your leg(s)	<input type="checkbox"/>	<input type="checkbox"/>	compression hose	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer on your leg(s)	<input type="checkbox"/>	<input type="checkbox"/>	medication	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue in your leg(s)	<input type="checkbox"/>	<input type="checkbox"/>	exercise/walking	<input type="checkbox"/>	<input type="checkbox"/>
The pain is made worse with:			Your pain feels like:		
Standing	<input type="checkbox"/>	<input type="checkbox"/>	ache/tiredness/heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	cramp	<input type="checkbox"/>	<input type="checkbox"/>
Before menses	<input type="checkbox"/>	<input type="checkbox"/>	burning	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>			

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