PATIENT HISTORY

Name:___________________________________

Date of birth:____________ **Age:**______ **Height:**_____ft_____in **Weight:**_______lbs **BP:**______ **Pulse:**______

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

Primary Care Physician: ___________________________________

Preferred Pharmacy: ___________________________________

Preferred primary language:

☐ English ☐ Other ____________________

Symptoms (Please check if yes)

	L	R	How long?
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
☐ Weight Loss
☐ Job Change
☐ Medical Grade Compression stockings or leg wraps?
Strength of stockings:_____________mmHg

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______________________

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

Provider reviewed with patient:____Date:____________

Name:____ Date of birth:____________

Please circle the conditions below that apply to you:

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

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)