VeinSolutions
Leaders in Therapeutic Vein Care

PATIENT HISTORY

Name:_____ **Today's date:**_____

Date of birth:_____ **Age:**_____ **Height:**_____ft_____in **Weight:**_____lbs **BP:**_____ **Pulse:**_____

Primary Care Physician: _____ **Preferred primary language:**

Preferred Pharmacy: _____ ☐ English ☐ Other _____

How did you hear about us?

☐ Physician (_____) ☐ Family/Friend ☐ Online ☐ TV ☐ 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

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

☐ Pain medications
☐ Exercise
☐ Leg elevation
☐ Medical Grade 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_____

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 an inflammation of a vein_____location	_____ yr	R	L

☐ 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)