Vein Clinic

Patient Information

Patient:_____ Today's Date: ____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Signature: _____

Self Referral? ☐ Yes ☐ No Referring MD: _____

Primary Doctor, if different: _____

Name of Insurance Carrier: _____

What is the reason for your visit today? ☐ Spider Veins ☐ Varicose Veins **(Answer all questions below)**

Medical History

1. **Have you had a prior Ultrasound study of your leg(s)?** ☐ YES ☐ NO
   Where: _____Date: ____/_____/_____
2. Which is your symptomatic leg? (Which leg is causing you problems?) ☐ Right ☐ Left ☐ Both
3. Have you ever had any bleeding complication from your varicose veins? ☐ YES ☐ NO
   If yes, please describe/explain: _____
   _____
4. Which of the following have you experienced and to what degree? Circle your degree for each symptom.

SYMPTOM	NONE	MILD → SEVERE				
Aching	0	1	2	3	4	5
Cramping	0	1	2	3	4	5
Burning	0	1	2	3	4	5
Itching	0	1	2	3	4	5
Redness	0	1	2	3	4	5
Ulcers	0	1	2	3	4	5
Swelling, especially after prolonged standing	0	1	2	3	4	5

5. Which, if any, of the following activities of daily living are impacted by your symptoms?
   a. **Employment:** ☐ Yes ☐ No If yes, what is your occupation: _____
   Describe how your symptoms impact your work: _____
   _____
   b. **Driving:** ☐ Yes ☐ No If yes, how often do you drive and distance/trip? _____
   _____
   c. Family care: ☐ Yes ☐ No If yes, for whom do you provide care? _____
   _____

Please complete the back of this form

d. Other activities of daily life (i.e., bathing, cleaning, cooking, shopping, etc.) ☐ Yes ☐ No

If yes, please describe: _____

_____

e. Exercise: ☐ Yes ☐ No

If yes, describe your daily exercise regime: _____

_____

PAST MEDICAL HISTORY:

1. **List other diseases from which you currently suffer (heart, lung, hypertension, pelvic inflammatory disease, etc.)** _____

_____

_____

2. List medical conditions/diseases you have suffered in the past: _____

_____

_____

3. List all surgeries (operations), reasons for surgery, and dates of each surgery:

_____

_____

4. Are you allergic to any medications? ☐ Yes ☐ No If yes, please list below:

_____

_____

CURRENT MEDICATIONS – include all prescribed medications, vitamins, herbals, over-the-counter medications (aspirin, ibuprophen, Tylenol, etc.)

MEDICATION	DOSE	HOW OFTEN TAKEN

Bring this completed form to your appointment.