IT IS IMPORTANT THAT THIS FORM IS FILLED OUT COMPLETELY. THANK YOU.

NAME_____**DATE (OF OFFICE VISIT)**_____

GENDER: ☐ **FEMALE** ☐ **MALE** **HEIGHT**_____**WEIGHT**_____**AGE**_____

◆REASON FOR VISIT:

☐ Varicose veins/legs ☐ Spider veins/legs
☐ Other_____

If you have varicose or spider veins/legs, when did they occur?
At age_____ Before pregnancy ☐ YES ☐ NO After pregnancy ☐ YES ☐ NO
After trauma ☐ YES ☐ NO After taking birth control or hormonal drug therapy ☐ YES ☐ NO
Other_____

Please describe your expectations of therapy_____

_____

◆PAST TREATMENT:

Have you ever been treated for the above problem(s)? ☐ YES ☐ NO
If yes, by whom?_____
When?_____What method? ☐ Sclerotherapy ☐ PhotoDerm ☐ 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_____
How do you take the medication: ☐ on a daily basis or ☐ as needed

◆FOR VARICOSE AND SPIDER VEINS OF THE LEGS COMPLETE THIS SECTION:

	RIGHT LEG	LEFT LEG		RIGHT LEG	LEFT LEG
Do you now have:			**The leg pain is better with...**		
-pain in your thigh?	☐	☐	-elevation of the leg	☐	☐
-pain in your calf?	☐	☐	-compression hose	☐	☐
-pain in your foot?	☐	☐	-medication	☐	☐
-ulcer on your legs?	☐	☐	-exercise/walking	☐	☐
-fatigue in your legs?	☐	☐	**Your pain feels like...**		
The pain is made worse with...			-an ache/tiredness/heaviness	☐	☐
-standing	☐	☐	-a cramp	☐	☐
-heat	☐	☐	-a burning	☐	☐
-before menses	☐	☐	-numbness	☐	☐

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

☐ YES ☐ NO COMMENTS_____

_____

◆PATIENT HISTORY:

VENOUS HISTORY: Please check if you have a history of:
☐ Phlebitis ☐ Leg ulcers ☐ Pulmonary embolus ☐ Use of anticoagulants (Heparin/Coumadin)
☐ Blood clots ☐ Leg injury ☐ Leg bone fracture ☐ Family history of varicose/spider veins

SURGICAL HISTORY: List surgical procedures you have had:

PROCEDURE	YEAR	OUTCOME

MEDICAL HISTORY: Please check if you currently have or have had a history of the following:

☐ High blood pressure	☐ Hepatitis	☐ Bleeding problems	☐ Hives
☐ Heart murmurs	☐ Heart attack	☐ Heart failure	☐ HIV/AIDS
☐ Diabetes	☐ Seizures	☐ Fainting spells	☐ Asthma
☐ Kidney disease	☐ Stroke	☐ Difficulty healing	☐ Arthritis
☐ Leukemia/Lymphoma	☐ Cancer	☐ Major accident	☐ Bowel problems

☐ Difficulty with anesthetic given at the dentist office

☐ History of unusual family illnesses_____

☐ Other medical condition(s) not listed_____

◆**CURRENT MEDICATIONS:**

1._____ 4._____

2._____ 5._____

3._____ 6._____

◆**ALLERGIES:**

_____

◆**SOCIAL HISTORY:**

ACTIVITY: Occupation_____Do you exercise regularly? ☐ YES ☐ NO

If yes, how?_____

Daily average time spent sitting?_____%/ standing?_____%

SMOKING: Do you smoke cigarettes? ☐ YES ☐ NO If yes, # of packs/day_____

ALCOHOL: Do you consume alcohol? ☐ YES ☐ NO If yes, # of drinks/day_____

◆**FOR FEMALE PATIENTS:**

Are you pregnant? ☐ YES ☐ NO ☐ UNSURE Date of last menstrual period_____

# of pregnancies_____# of children_____Are you currently breastfeeding? ☐ YES ☐ NO

Are you taking birth control pills or other hormones? ☐ YES ☐ NO

Have you had a tubal ligation or hysterectomy? ☐ YES ☐ NO

◆**FOR PHYSICIAN USE:**

COMMENTS:_____

_____

I have reviewed the above information, completed by the patient, with the patient.

PHYSICIAN SIGNATURE:_____