[redacted]

PATIENT INFORMATION FORM

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **DOB:** _____/_____/_____ **Age:** _____

Address: _____

E-mail address: _____**Home Phone:** _____ **Alternate Phone:** _____

How did you hear about us? ☐ **Radio** ☐**TV** ☐**Internet** ☐**Billboard** ☐**Friend/Relative** ☐**Print Ad**

☐**Physician** _____ ☐ **Other** _____

Personal Physician: *(name and phone number)* _____

OB/GYN: *(name and phone number)* _____

Allergies *(including local anesthetics, i.e. Xylocaine/ Lidocaine/ EMLA/ Tetracaine, latex)*: _____

List Current Medications/Vitamins/Herbal Supplements: _____

_____

Are you currently taking:

Contraceptives/Female Hormones	*yes*	*no*	**Anticoagulant** *(blood thinner)*	*yes*	*no*
Aspirin	*yes*	*no*	**Digoxin**	*yes*	*no*
Steroids	*yes*	*no*	**Antibiotics during dental work**	*yes*	*no*

Are you Pregnant, nursing or planning a pregnancy in the near future? *yes* *no*

Number of Pregnancies: _____ **Date of last Pregnancy:** _____

<u>Present Health:</u>

Date of last medical check-up/Physical exam: _____

Are you currently under the care of a physician for any medical illness or condition? *If yes, please explain*:

_____

Circle symptoms which you have now or have had in the past:

High Blood Pressure	**Heart Disease**	**Hepatitis**	**Endocrine Dysfunction**	**Diabetes**
HIV/AIDS	**Overweight**	**Arthritis**	**Poor Circulation**	**Gout**
Cold Sores or Herpes Simplex infection				

Medical History :*(list diseases and age):* _____

_____

Cardiovascular:

Weakness	**Chest pain**	**Edema** *(swelling of hands, face, feet)*	**Heart Attack** *(MI)*
Stroke *(CVA)*	**Change in rate or rhythm of heart beat**	**Congestive heart failure** *(CHF)*	
Poor Circulation	**Cramping or pain in legs when walking**		

Comments:

_____

_____

Surgeries/Hospitalizations: *(list all procedures, admissions and ages)*: _____

_____

_____

Social History: Alcohol Consumption #____per day occasional/social
Smoking (*cigarettes per day):* _____ **Marital Status:** _____ **No. of Children:** _____
Occupation: _____

Reason for Visit: *Spider Veins Varicose Veins other:* _____
Age you first noticed veins: _____
Family History of Varicose or Spider Veins or Leg ulcers: *yes no*
if yes, specify: _____

Do you have or have you had: *(please circle all that apply)*

Unsightly veins	*right*	*left*	**Aches and Pains (legs)**	*right*	*left*
Heaviness or tired legs	*right*	*left*	**Ankle Edema (swelling)**	*right*	*left*
Itching	*right*	*left*	**Night leg cramps**	*right*	*left*
Bleeding for the Vein	*right*	*left*	**Dermatitis (rash)**	*right*	*left*
Restless legs	*right*	*left*	**Burning**	*right*	*left*
Discoloration of skin	*right*	*left*	**Throbbing**	*right*	*left*
Active Ulceration (break down of skin and open sore)				*right*	*left*
Healed ulceration				*right*	*left*

Other: *(please describe)*: _____

Are your symptoms worse with:

Standing	*right*	*left*	**Sitting**	*right*	*left*
With heat	*right*	*left*	**Walking/Exercise**	*right*	*left*
Premenstrual	*right*	*left*	**Night**	*right*	*left*
Pregnancy	*right*	*left*			

Are you developing new veins/Noticed a deterioration recently? *yes no*
Bleeding or clotting disorders? *(Excessive bleeding)* *yes no*
Please check any methods you have used to relieve leg discomfort:

___	No Discomfort	___	Leg elevation	___	Exercise	___	Warm Soaks
___	Cold Packs	___	Walking	___	Tylenol	___	Pain Medications
___	Flexion/extension of feet	___	Wraps	___	Aspirin	___	Ibuprofen

Other methods:_____

What is earliest date that you started taking pain medication for leg problems (aspirin, Tylenol, Ibuprofen, other pain meds) and what was the outcome?_____

What is the earliest date that you wore medical support hose for your leg problems?* _____
What compression are they? _____ (15mmHg, 20mmHg, 30 mmHg, etc.)
How long did you wear compression hose? _____

Some insurance plans require that compression hose be worn prior to request for treatment.

How have your daily activities been affected or limited by your leg problems? If yes, how? _____
_____

Are you on your feet for long periods? _____ In what capacity? _____

Does walking/exercise relieve your discomfort or make it worse? _____

Other: _____

_____

Have you ever had any of the following:			**Date**	**By Whom**
Vein Evaluation	*right*	*left*	_____	_____
Venogram, ultrasound, other tests	*right*	*left*	_____	_____
Superficial phlebitis	*right*	*left*	_____	_____
Inflammation of vein (skin over vein becomes red, warm & tender)	*right*	*left*	_____	_____
Deep Thrombo-phlebitis (blood clot)	*right*	*left*	_____	_____
Pulmonary emboli (blood clot to lungs)	*right*	*left*	_____	_____

What was the result? _____

Previous treatment modalities:			**Date**	**How long did you wear**
Compression stockings	*right*		_____	_____
Compression stockings		*left*	_____	_____

			Date	**By Whom**
Ligation Surgery (vein tied off)	*right*	*left*	_____	_____
Stripping Surgery *(removal of vein from ankle to groin or behind knee to Achilles)*	*right*	*left*	_____	_____
Local Excision *(remove the bulging veins)*	*right*	*left*	_____	_____
Electrocautery *(electric needle)*	*right*	*left*	_____	_____
Laser *(special light directed at the vein)*	*right*	*left*	_____	_____
Sclerotherapy *(injection treatment of solution or medicine into the veins)*	*right*	*left*	_____	_____

Have you had a DEXA (bone density) performed? _____ If yes, when was this test performed? _____
Or have you been on pharmacologic therapy? _____If yes, when was this prescribed? _____

If you are a female 65 years of age or older, have you been assessed for the presence or absence of urinary incontinence within? _____ If yes, when were you assessed? _____

Have you received a flu vaccine?_____ if yes, what date_____

If you are 65 years of age or older, have you received a pneumonia vaccine? _____ if yes, what date _____

If you are a woman age 50-74, when was your last screening mammogram? _____

If you are age 50-75, have you had a colorectal screening? _____ If yes, when _____

If you are a current or former smoker, have you been screened for tobacco use and have you received cessation counseling intervention if identified as a tobacco user? _____ Have you received counseling and/or pharmacotherapy

_____

What about your legs would you most like to correct? _____

_____

Comments: _____

_____

_____

This document must be filled out in its entirety to assure optimal patient care and to assist us in qualifying you for insurance coverage to treat your condition.

Patient Signature: _____ **Date:** _____

Patient's Representative Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Allied Health Professional Signature: _____ **Date:** _____

***(If patient is a minor or mentally incompetent, signature of parent or legal guardian is required.)*