VCS vein care specialists

PATIENT INFORMATION FORM

Name: _____ **Date:** _____
Height: _____ **Weight:** _____ **DOB:** _____ /_____ /_____ **Age:** _____
Address: _____
E-mail address: _____ **Home Phone:** _____ **Alternate Phone:** _____
How did you hear about us? *(Circle all that apply)* **Radio TV Internet Billboard Friend/Relative Print Ad**
Physician _____ **Other** _____
Reason for Visit: Spider Veins Varicose Veins Other: _____

Primary Physician: *(Name and Phone Number)* _____
OB/GYN: *(Name and Phone Number)* _____
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 if 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
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*

Do you have now or have you had in the past: *(Circle all that apply)*

High Blood Pressure	**Heart Disease**	**Hepatitis**	**Endocrine Dysfunction**	**Diabetes**
HIV/AIDS	**Overweight**	**Arthritis**	**Poor Circulation**	**Gout**

Cold Sores or Herpes Simplex infection
Cardiovascular : *(Circle all that apply)*

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

Are you Pregnant, nursing or planning a pregnancy in the near future? *yes no*
Number of Pregnancies: _____ **Number of Children:** _____**Date of last Pregnancy:** _____
Surgeries/Hospitalizations: *(List all procedures, admissions and ages)*:_____

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Social History:

Alcohol Consumption: #____ per day, *(Circle which applies)* **Occasionally or Socially**

Smoking: # ____cigarettes per day

Marital Status: _____ Occupation: _____

Age you first noticed veins: _____

Family History of Varicose or Spider Veins or Leg ulcers: *yes no*

If yes, please specify: _____

Have you experienced now or in the past: *(Please specify in which leg. 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 from 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*

Are your symptoms worse with: *(Please specify in which leg. Circle all that apply)*

Standing	*right*	*left*	**Sitting**	*right*	*left*
Heat	*right*	*left*	**Walking/Exercise**	*right*	*left*
Premenstrual	*right*	*left*	**Night**	*right*	*left*
Pregnancy	*right*	*left*			

Have used any of the following to relieve leg discomfort: *(Circle all that apply)*

Pain Medications: Tylenol Aspirin Ibuprofen How long have you been taking the pain medication: _____

No Discomfort Leg elevation Exercise Warm Soaks Flexion/Extension of feet

Cold Packs Walking Wraps

Have your daily activities been affected or limited by your leg problems? *yes no*

If yes, how? _____

Are you on your feet for long periods? *yes no* **In what capacity?**_____

Have you tried wearing medical support hose for your leg problems? *yes no*

If so, what was the date and how long ago did you first start wearing the medical support hose? Date/Time Frame

Compression hose/stocking *right leg* _____

Compression hose/stocking *left leg* _____

What compression? *(15mmHg, 20mmHg, 30 mmHg, etc.)* **Compression**

Compression hose/stocking *right leg* _____

Compression hose/stocking *left leg* _____

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

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*	_____	_____
Ligation Surgery *(vein tied off)*	*right*	*left*	_____	_____

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

Have you had a DEXA (bone density) performed? *yes no* **If yes, when was this test performed?** _____

Have you been on pharmacologic therapy? *yes no* **If yes, when was this prescribed?**_____

Have you received a flu vaccine? *yes no* **If yes, when** _____

If you are 65 years of age or older, have you received a pneumonia vaccine? *yes no* **If yes, when** _____

If you are age 50-75, have you had a colorectal screening? *yes no* **If yes, when** _____

Females Only:

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

yes no **If yes, when were you assessed?** _____

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

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.)*