MR#: ____________________

DATE:_____ /_____ /_____ E-MAIL ADDRESS: ____________________

PATIENT: ____________________ AGE: __________

NICK NAME: ____________________

PHONE # ____________________ CELL # ____________________

ADDRESS:____________________ CITY:__________ STATE: __________ ZIP: __________

MARITAL STATUS (circle one) M S W D SPOUSE NAME____________________

EMERGENCY CONTACT NAME: ____________________ PHONE NUMBER: __________ RELATIONSHIP: __________

ADDRESS: ____________________ CITY: __________ STATE: __________ ZIP: __________

EMPLOYER: ____________________ / RETIRED _______ WORK PHONE #: ____________________

REFERRING DR: ____________________ PHONE #:____________________

ADDRESS: ____________________ CITY: __________ STATE: __________ ZIP: __________

PRIMARY PHYSICIAN:____________________ PHONE #:____________________

ADDRESS: ____________________ CITY: __________ STATE: __________ ZIP: __________

LAST WEIGHT:__________ LBS_______HEIGHT: ________ FT________ INCHES

REFERRAL SOURCE:

[ ] DOCTORS OFFICE [ ] BILL BOARD [ ] FACEBOOK [ ] FRIEND

[ ] RETURNING PATIENT [ ] PHONE BOOK [ ] TV / RADIO [ ] WEBSITE

[ ] HEALTH FAIR: ____________________ [ ] SEMINAR: ____________________

[ ] MAGAZINE: ____________________ [ ] NEWSPAPER: ____________________

[ ] VEIN SCREENING: ____________________ [ ] OTHER:____________________

REVIEW OF SYSTEMS

MARK EACH ITEM AS "YES" OR "NO"

Name: ______________________ **DOB:** ____-____-_____ **MR#:** ____________________

CONSTITUTIONAL	YES	NO
Weight Loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Change in Appetite	☐	☐

SKIN	YES	NO
Rash/ Sores	☐	☐
Lesions/ Open Wounds	☐	☐
Itching	☐	☐
Burning	☐	☐
Bruising	☐	☐
Dryness	☐	☐
Color Changes	☐	☐

EYES	YES	NO
Glasses or Contacts	☐	☐
Pain	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

EARS, NOSE & THROAT	YES	NO
Ringing in Ears	☐	☐
Vertigo/Dizziness	☐	☐
Frequent Sore Throat	☐	☐
Hoarseness	☐	☐
Frequent Nose Bleeds	☐	☐
Decreased Hearing	☐	☐

RESPIRATORY	YES	NO
Shortness of Breath	☐	☐
Persistent Cough	☐	☐
Cough blood	☐	☐
Frequent Infections	☐	☐
Wheezing	☐	☐

CARDIOVASCULAR	YES	NO
Chest Pain / Angina	☐	☐
Irregular Heart Beat	☐	☐
Arm Pain	☐	☐
Palpitations	☐	☐
Swelling of Extremities	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Calf Cramps with Walking	☐	☐
Deep vein clot	☐	☐

GASTROINTESTINAL	YES	NO
Abdominal Pain	☐	☐
Nausea / Vomiting	☐	☐
Heartburn	☐	☐
Rectal Bleeding	☐	☐
Diarrhea /Constipation	☐	☐
Hemorrhoids	☐	☐
Colonoscopy	☐	☐
Date_______________		

GENITOURINARY	YES	NO
Pain when Urinating	☐	☐
Burns when Urinating	☐	☐
Frequent Urination	☐	☐
Blood in Urine	☐	☐
History of Sexually	☐	☐
Transmitted Disease	☐	☐

MUSCULOSKELETAL	YES	NO
Joint Pain/ Swelling	☐	☐
Joint Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
Compression Hose	☐	☐
Decrease Range of	☐	☐
Motion	☐	☐
Physical Disability	☐	☐
Prosthesis	☐	☐
Location____________		

NEUROLOGIC	YES	NO
Seizures	☐	☐
Headaches/ Migraine	☐	☐
Numbness	☐	☐
Memory Loss	☐	☐
Loss of Consciousness	☐	☐
Dizziness / Fainting	☐	☐

PSYCHIATRIC	YES	NO
Anxiety	☐	☐
Sleep Disorders	☐	☐
Mood Changes	☐	☐
Depression	☐	☐

ENDOCRINE	YES	NO
Change in nails	☐	☐
Heat / Cold Intolerance	☐	☐
Thyroid Problems	☐	☐
Hormone Therapy	☐	☐
Diabetic	☐	☐
Dialysis	☐	☐

HEMATOLOGIC	YES	NO
Bruises Easily	☐	☐
HIV / AIDS	☐	☐
Hepatitis	☐	☐
Prolonged Bleeding	☐	☐
Clotting Disorder	☐	☐

ALLERGY/ IMMUNOLOGIC	YES	NO
Hay Fever	☐	☐
Asthma	☐	☐
Hives/Eczema	☐	☐
Seasonal Pollen	☐	☐
Fibromyalgia	☐	☐

PAIN RELIEF	YES	NO
Do analgesics	☐	☐
(medication)	☐	☐
relieve pain in legs?	☐	☐

Name:____ **MR#:**____________________

My main area of concern is: ____

ARE YOUR LEGS EVER BOTHERED BY: CIRCLE EACH ONE AS APPROPRIATE

- ACHING/PAIN
- THROBBING
- NUMBNESS
- TINGLING
- BURNING
- ITCHING
- FULLNESS
- PRESSURE
- SWELLING
- TIREDNESS
- HEAVINESS
- RESTLESSNESS
- MUSCLE CRAMPING
- SKIN OPEN WOUNDS or ULCER
- SKIN DISCOLORATION

CIRCLE each of the following treatments you have had and limb

TREATMENT	LEG		
Sclerotherapy (legs)	RT or Left or Both	Date of last treatment	_____-_____-_______
Surgery for veins (stripping)	RT or Left or Both	Date of last treatment	_____-_____-_______
Spider Veins	RT or Left or Both	Date of last treatment	_____-_____-_______
EVLT (laser)	RT or Left or Both	Date of last treatment	_____-_____-_______
Compression hose	RT or Left or Both	Date started	_____-_____-_______

DO YOUR LEGS EVER FEEL: (CIRCLE ANSWER)

After prolonged sitting or standing	**Better / Worse**
During menstrual period	**Better / Worse / NA**
During warm weather	**Better / Worse**
While walking. Number of blocks ________	**Better / Worse**
After elevating	**Better / Worse**
While wearing support stockings	**Better / Worse / NA**

Have you ever had a blood clot in your legs? **Yes / No**

DOES YOUR WORK REQUIRE? (CIRCLE ANSWER)

Prolonged periods of standing? **Yes / No**

Prolonged periods of sitting? **Yes / No**

What is your present or past occupation ______________________________. Years in that occupation ______

Do you use any assistive devices? Yes / No What type- CIRCLE: **Walker, Cane, Wheelchair**

Do you feel your veins are causing a limitation to your life style? **Yes / No**

Does it affect your work? **Yes / No**

SOCIAL: (CIRCLE ANSWER)

Do you smoke or use tobacco products? **Yes / No** Type_______

If Yes, how much? ______ packs per day. How long _____ yrs

Do you drink alcohol? **Yes / No** Amount per day _______ How long _______ yrs

History of migraines? **Yes / No** Typical duration? _____ hrs. Date of last migraine____-____-______

FEMALE ONLY- CIRCLE OR WRITE ANSWERS:

Number of pregnancy's _____ How many births _____ Current age of children ___,____,____,___

Pregnant now: **Yes / No** If Yes how many months ________ Do you plan on becoming pregnant? **Yes / No**

Did you notice leg veins during pregnancy'(s)? **Yes / No**

Name: ______________________ MR#: ____________

PAST SURGICAL HISTORY / DATE: ______________________

____

____

____

ALLERGIES: ________ **YES** ________ **NO (Include medication, food, latex, medical adhesive, etc....)**

If yes, then please complete the following:

I am allergic to:	The reaction I have to this allergy is:

CIRCLE ALL ISSUES THAT APPLY TO FAMILY HISTORY (Parents, grandparents, siblings)

- Diabetes
- Heart Disease
- Stroke
- High blood pressure
- Vascular Disease
- High Cholesterol
- Clotting disorders
- Long bleeding times
- Obesity

MEDICATION LIST

Do you take any medications? ________ **YES** ________ **NO If YES, please include all over the counter and prescribed:**
List ALL medications that you are currently taking.

Pharmacy Name: ____________ **Location:** ______________________

Mail order Pharmacy name: ______________________

Medication Name	Dose/mg	How often taken