Name:
DOB:
MR#:

REVIEW OF SYSTEMS

Last Weight: _____ lbs Height: _____Ft _____In

Please check all that apply:

CONSTITUTIONAL
- ☐ Recent Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Change in Appetite

SKIN
- ☐ Rash / Sores
- ☐ Lesions/Open Wounds
- ☐ Itching
- ☐ Burning
- ☐ Bruising
- ☐ Dryness
- ☐ Color Changes

EYES
- ☐ Glasses/Contacts
- ☐ Pain
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts

EARS, NOSE & THROAT
- ☐ Ringing in Ears
- ☐ Vertigo / Dizziness
- ☐ Frequent Sore Throat
- ☐ Hoarseness
- ☐ Frequent Nose Bleeds
- ☐ Decreased Hearing

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Cough Blood
- ☐ Frequent Infections
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain / Angina
- ☐ Irregular Heartbeat
- ☐ Arm Pain
- ☐ Palpitations
- ☐ Swelling of Extremities
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Calf Cramps Walking
- ☐ Deep Vein Clot

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Diarrhea / Constipation
- ☐ Hemorrhoids
- ☐ Colonoscopy
  Date: _____

GENITOURINARY
- ☐ Pain Urinating
- ☐ Burning Urinating
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ History of Sexually Transmitted Disease

MUSCULOSKELETAL
- ☐ Joint Pain / Swelling
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Compression Hose
  Start Date: _____
- ☐ Decrease Range of Motion
- ☐ Physical Disability
- ☐ Prosthesis
  Location: _____

NEUROLOGIC
- ☐ Seizures
- ☐ Headaches / Migraine
  Duration in Hours: _____
  Date of Last Migraine:_____
- ☐ Numbness
- ☐ Memory Loss
- ☐ Loss of Consciousness
- ☐ Dizziness / Fainting

PSYCHIATRIC
- ☐ Anxiety
- ☐ Sleep Disorders
- ☐ Mood Changes
- ☐ Depression

ENDOCRINE
- ☐ Change in Nails
- ☐ Heat / Cold Intolerance
- ☐ Thyroid Problems
- ☐ Hormone Therapy
- ☐ Diabetic
- ☐ Dialysis

HEMATOLOGIC
- ☐ Bruises Easily
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Prolonged Bleeding
- ☐ Clotting Disorder

ALLERGY / IMMUNOLOGIC
- ☐ Hay Fever
- ☐ Asthma
- ☐ Hives / Eczema
- ☐ Seasonal Pollen
- ☐ Fibromyalgia

PAIN RELIEF
- ☐ Do analgesics (medications) Relieve Leg Pain?

Name:
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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 the associated 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 _____-_____-_____

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 _____ Number of 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)

Marriage Status: M / S / D / W Spouse / Partner Name (if applicable): _____

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 / week _____ How long _____ yrs

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:
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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 currently take any medications? **YES / NO** If YES, please list all over the counter and prescribed medications.

Pharmacy Name: _____ Location: _____

Mail order Pharmacy name:_____

Medication Name	**Dose/mg**	**How Often Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____