Advanced Venous Center
Vein Consultation

Today's Date: ________________________
Name: ____DOB:_________________________________
Address: ____________________________City:_________________Sate:_______ZipCode:_________
Phone:__________________________________Email: ______________________________________
Insurance:____Card Copied: Yes No
How did you hear about us?: ____

History:

Leg pain/Cramping	Yes	No	Left	Right
Swelling/Edema	Yes	No	Left	Right
Fatigue	Yes	No	Left	Right
Heaviness in legs	Yes	No	Left	Right
Itching/Burning	Yes	No	Left	Right
Sensation Loss	Yes	No	Left	Right
Bleeding from veins	Yes	No	Left	Right
Spontaneous Bruising	Yes	No	Left	Right
Phlebitis	Yes	No	Left	Right
Ulcer	Yes	No	Left	Right

How long have you had these symptoms?____________________________________
Symptoms occur with: Laying down Standing Sitting Walking Sleeping
Women: Are symptoms worse with menstruation? Yes No N/A
Are you currently breast feeding? Yes No N/A

What have you tried to relieve these symptoms?

Leg Elevation Weight Loss Compression Hose
For how long? _______________________

Have you had any prior vein treatments? Yes No Left Right
Sclerotherapy-- Laser Ablation -- Microphlebectomy-- Vein Stripping-- Radio-Frequency Ablation

When: ______________________ By Whom: ________________________________

Medical History:

Diabetes	Yes	No	Migraines	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Blood Clots in legs	Yes	No			

Medications:

Blood Thinners	Yes	No	Type: ______________________________
Insulin	Yes	No	
Steroids	Yes	No	
Antibiotics	Yes	No	
Pain Medication	Yes	No	
Hormone Replacement	Yes	No	
Birth Control	Yes	No	

Patient Signature: ____**Date**__________________