# MINNEAPOLIS VEIN CENTER

*Experts in Vein Care*

**Patient Name:** ________________________________ **Date of Visit:** ______________

**Date of Birth:** ________________ **Height:**___________ **Weight**_____________________

**How did you hear about the Minneapolis Vein Center?** __________________________________

Who is your regular primary physician? ____________________________________________

What other physicians do you see?_______________________________________________

What is your most significant symptom?____________________________________________

**Vein History**

Which leg is affected? Right Left

Which leg is worse? Right Left

How are your daily activites affected by your legs?____________________________________

__________________________________________________________________________

How long have your legs bothered you? Years:_____ Months:________

**Circle Rt (right) or Lt (left) or both if you CURRENTLY experience any of the following leg symptoms.**

| | | | |
|---|---|---|---|
| Aching/pain in your legs | Rt Lt | Heaviness | Rt Lt |
| Tiredness/fatigue | Rt Lt | Itching/burning | Rt Lt |
| Swollen Ankles | Rt Lt | Leg cramps | Rt Lt |
| Restless Legs | Rt Lt | Throbbing | Rt Lt |
| Leg wound(s) | Rt Lt | Groin varicose veins | Rt Lt |

Other: ____________________________________________________________________

**For women only**

Do you have deep pelvic pain? Yes No

Do you have pain with intercourse? Yes No

Are your symptoms in either your pelvis or legs worse with your menstrual period? Yes No

**What have you tried to improve your leg symptoms? (Circle all that apply.)**

**Elevate Walk Ice Massage Stockings Ace wraps Pain medication**

If you circled elevation: How often? _______ For how long each time? _______Since when?_________

If you circled pain medication, circle which one(s): Aspirin Ibuprofen Aleve Tylenol Other:__________

For how long have you used it? __________ How often? ___________ Does it help? _________

**Do you have any concerns about the appearance of you leg(s)?** YES NO

If yes, please describe:_________________________________________________________

If yes, would you like to hear about cosmetic treatments, if appropriate? YES NO

**Prior Vein Evaluation and Treatment**

Have you ever had your veins evaluated by a doctor before? Yes No

If yes, what doctor and when? ____________________________________________________________

Did the doctor perform any tests (for example, an ultrasound)? Yes No

If you have had any of the following leg vein treatments, circle which leg and fill in when.

**Stripping**: Rt Lt_______ **Venous Ablation:** Rt Lt_______ **Phlebectomy:** Rt Lt_______ **Sclerotherapy**: Rt Lt_______

Circle if you have previously had: Deep Vein Clot (DVT) Superficial Blood Clot (Phlebitis) Leg Wound

Please describe:____________________________________________________________________________________

**Compression Stocking Use**

Have you ever worn compression stockings in the past? Yes No

If yes, when? ____________ If yes, for what length of time? Years:______ Months:______

Do you currently wear **prescription** compression stockings? Yes No

If yes, do they help? Yes No

If no, why not? ____________________________________________________________________

Name of physician who prescribed your stockings: ______________________________________

**PAST MEDICAL HISTORY**

Are you presently under the care of a physician for any illness? Yes No

If yes, please explain: ________________________________________________________________

Have you ever had surgery of any kind? Yes No

If yes, please specify: ________________________________________________________________________

____________________________________________________________________________________________

Have you ever been hospitalized for anything other than surgery? Yes No

If yes, please specify: ________________________________________________________________________

____________________________________________________________________________________________

**Have you ever been told that you should NOT take Ibuprofen? Yes No**

If yes, why?__________________________________

**Do you have any of the following?**

| Condition | | Condition | |
|---|---|---|---|
| Congestive Heart Failure | Yes No | Tendonitis | Yes No |
| Back Pain | Yes No | Heart Disease | Yes No |
| Lung Disease | Yes No | Pacemaker | Yes No |
| Anemia | Yes No | Hepatitis | Yes No |
| Arthritis | Yes No | Diabetes | Yes No |
| High Cholesterol | Yes No | Asthma | Yes No |
| Thyroid | Yes No | Migraine | Yes No |
| High Blood Pressure | Yes No | Kidney Disease | Yes No |

If you circled **YES** to any of the above, please describe:__________________________________________________________

Other significant medical history not listed above: ____________________________________________________________

**For women only**

| | | |
|---|---|---|
| Currently pregnant? | Yes | No |
| How many times have you been pregnant? | ______________ | |
| How many live childbirths? | ______________ | |
| Currently breastfeeding? | Yes | No |
| Planning on becoming pregnant? | Yes | No |

**Please list all current medications (prescription & over the counter) you are taking.**

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have medication allergies? Reaction:

Are you allergic to shrimp/shellfish/iodine, IVP dye and/or IV contrast dye? If yes, please circle.
If yes, what type of reaction did you have?________________________________

**Family History**

It is important for us to know your family medical history. Please include if any family member has experienced any of the foll
Circle all the apply.

**Varicose Veins:** Mother Father Brothers Sisters Children

**Heart Disease:** Mother Father Brothers Sisters Children

**Blood Clots:** Mother Father Brothers Sisters Children

**Diabetes:** Mother Father Brothers Sisters Children

**Fibroids:** Mother Father Brothers Sisters Children

**High Blood Pressure:** Mother Father Brothers Sisters Children

**Congestive Heart Failure:** Mother Father Brothers Sisters Children

**Cancer:** Mother: Type__________ Father: Type____________ Brothers: Type____________
Sisters: Type___________ Children: Type____________

**Social History**

What is your profession? __________________________________________________
Do you smoke? _____ Did you ever? ______ When did you quit? ___________________
Do you drink alcohol? ____ If yes, how much? __________________________________
Does anyone live at home with you? ______ Who? ______________________________________