CONFIDENTIAL HEALTH & VASCULAR HISTORY: MEN

PATIENT INFORMATION

Name: ____ Date: ________________

Age: ______ sex: ______ height: ______ weight: ______ Years with varicose / spider veins? __________

What about your legs would you most like to correct? _____________________________________

____

HOW DID YOU HEAR ABOUT US?

Referring Doctor: _________________________ Other: __________________________

SYMPTOMS

Please check if you have:

_ Red spider veins
_ Bulging veins
_ Ankle sores
_ Other: ________________________________
_ Abdominal veins
_ Purple veins
_ Flat bluish-green veins
_ Skin discoloration below your knee
_ Diagnosis of vein disease
_ Purple vein network

Do your legs or ankles:

_ Ache or hurt? Please describe: ____________________________________
_ Swell? Please describe: ____________________________________
_ Cramp? Please describe: ____________________________________
_ Become restless? Please describe: ____________________________________
_ Become tired / heavy? Please describe: ____________________________________
_ Itch? Please describe: ____________________________________
_ Other? Please describe: ____________________________________

MEDICAL HISTORY

Is there a history in your **FAMILY** of spider or varicose veins?
Describe which:

_ Mom: ______________ _ Dad: ______________ _ Siblings: ______________
_ Aunt / Uncle: ______________ _ Grandparents: ______________ _ Child: ____________

Is there a history in your **FAMILY** of deep venous thrombosis, stroke or clotting disorders?
Describe which:

_ Mom: ______________ _ Dad: ______________ _ Siblings: ______________
_ Aunt / Uncle: ______________ _ Grandparents: ______________ _ Child: ____________

Do **YOU** have a history of:

_ Anemia	_ HIV
_ Ankle Skin changes	_ Hypertension
_ Atherosclerosis	_ Kidney disease
_ Asthma	_ Leg ulcers
_ Bleeding/Blood disorder	_Liver disease
_ Chest pain discomfort	_ Lupus
_ Constipation	_ Migraine headaches
_ Crohn's disease, IBS	_ Mitral valve prolapse
_ Deep Vein Thrombosis/clot	_ Pulmonary embolus (blood clots in lungs)
_ Diabetes; Insulin dependent	_ Rupture of a vein
_ Easy bruising	_ Superficial Thrombophlebitis (blood clots in skin veins)
_ Gout	_ Trauma to your legs
_ Heart disease	_ Other: ___________________________
_ Hepatitis	_ Other: ___________________________

Surgeries – Procedures and Dates

1.
2.
3.
4.
5.

Medical Hospitalizations – Disease and Age

1.
2.
3.
4.

<u>CURRENT MEDICAL INFORMATION</u>

Are you currently on?

Aspirin	_ Yes	_ No
Steroids	_ Yes	_ No
Anticoagulants (Coumadin/Heparin)	_ Yes	_ No
Arthritis Medications	_ Yes	_ No
Digoxin	_ Yes	_ No

Other: ____________________________________ Other: ____________________________________

Other: ____________________________________ Other: ____________________________________

Do you have allergies or sensitivities to medicines or tape? List all: ____

____

Are you being treated for any illnesses or conditions? _ Yes _ No If so, what illness: ___________________

Social History:

Do you smoke? Yes - No Previously? How many years? ____

Drink Alcohol? Yes? - No Socially? Occasionally? Frequently?

VASCULAR HISTORY

Please check any methods you have used to relieve your leg discomfort:

_ No Discomfort	_ Warm Soaks	_ Leg Elevation
_ Cold Packs	_ Exercise	_ Pain Meds
_ Flexion/Extension of your feet	_ Aspirin	_ Walking
_ Tylenol	_ Support Hose	_ Ibuprofen
_ Wraps	_ Other Method: ________________________________	

Are you on your feet for long periods? _ Yes _ No In what capacity? ______________________________

____

Does walking/exercise relieve your discomfort or make it worse? ________________________________

Have you been treated for your veins before? _ Yes _ No

By whom? ______________________________ When: ____________________________________

What method?

_ Injections	_ Radiofrequency Closure
_ Stripping	_ Laser Catheter Ablation
_ Ambulatory Phlebectomy	_ Laser for Spider Vein
_ Ligation	_ Ultrasound-Guided Injections
_ Other: ____________________________	

What have your results been? ____

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