



## CONFIDENTIAL HEALTH & VASCULAR HISTORY: WOMEN

### 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:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Red spider veins | <input type="checkbox"/> abdominal veins         | <input type="checkbox"/> Skin discoloration below your knee |
| <input type="checkbox"/> Bulging veins    | <input type="checkbox"/> Purple veins            | <input type="checkbox"/> Diagnosis of vein disease          |
| <input type="checkbox"/> Ankle sores      | <input type="checkbox"/> Flat bluish-green veins | <input type="checkbox"/> Purple vein network                |
| <input type="checkbox"/> Other: _____     |  |   |

Do your legs or ankles:

- |  |                        |
|--|------------------------|
| <input type="checkbox"/> Ache or hurt?         | Please describe: _____ |
| <input type="checkbox"/> Swell?                | Please describe: _____ |
| <input type="checkbox"/> Cramp?                | Please describe: _____ |
| <input type="checkbox"/> Become restless?      | Please describe: _____ |
| <input type="checkbox"/> Become tired / heavy? | Please describe: _____ |
| <input type="checkbox"/> Itch?                 | Please describe: _____ |
| <input type="checkbox"/> 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: \_\_\_\_\_

**Social History:**

Do you smoke? Yes - No Previously? How many years? \_\_\_\_

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

Do YOU have a history of:

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> HIV  |
| <input type="checkbox"/> Ankle Skin changes          | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Atherosclerosis             | <input type="checkbox"/> Kidney disease   |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Leg ulcers   |
| <input type="checkbox"/> Bleeding/Blood disorder     | <input type="checkbox"/> Liver disease  |
| <input type="checkbox"/> Chest pain discomfort       | <input type="checkbox"/> Lupus  |
| <input type="checkbox"/> Constipation                | <input type="checkbox"/> Migraine headaches   |
| <input type="checkbox"/> Crohn's disease, IBS        | <input type="checkbox"/> Mitral valve prolapse  |
| <input type="checkbox"/> Deep Vein Thrombosis/clot   | <input type="checkbox"/> Pulmonary embolus (blood clots in lungs)                       |
| <input type="checkbox"/> Diabetes; Insulin dependent | <input type="checkbox"/> Rupture of a vein  |
| <input type="checkbox"/> Easy bruising               | <input type="checkbox"/> Superficial Thrombophlebitis (clotting of veins at skin level) |
| <input type="checkbox"/> Gout                        | <input type="checkbox"/> Trauma to your legs  |
| <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Other: _____   |

**Surgeries – Procedures and Dates**

- 1.
- 2.
- 3.
- 4.
- 5.

**Medical Hospitalizations – Disease and Age**

- 1.
- 2.
- 3.
- 4.
- 5.

**CURRENT MEDICAL INFORMATION**

Are you currently on?

- |                                   |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|
| Birth Control Pills               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aspirin                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Steroids                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anticoagulants (Coumadin/Heparin) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis Medications             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Digoxin                           | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: \_\_\_\_\_

Are you pregnant or planning to be soon?                     Yes                     No

Number of pregnancies: \_\_\_\_\_                    Number of stillbirth / miscarriages: \_\_\_\_\_

Are you currently breastfeeding?                     Yes                     No

Do you have more leg discomfort around your menses?  Yes                     No

**VASCULAR HISTORY**

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> No Discomfort                  | <input type="checkbox"/> Warm Soaks          | <input type="checkbox"/> Leg Elevation |
| <input type="checkbox"/> Cold Packs                     | <input type="checkbox"/> Exercise            | <input type="checkbox"/> Pain Meds     |
| <input type="checkbox"/> Flexion/Extension of your feet | <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Walking       |
| <input type="checkbox"/> Tylenol                        | <input type="checkbox"/> Support Hose        | <input type="checkbox"/> Ibuprofen     |
| <input type="checkbox"/> Wraps                          | <input type="checkbox"/> 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?

- |   |   |
|---|---|
| <input type="checkbox"/> Injections             | <input type="checkbox"/> Radiofrequency Closure       |
| <input type="checkbox"/> Stripping              | <input type="checkbox"/> Laser Catheter Ablation      |
| <input type="checkbox"/> Ambulatory Phlebectomy | <input type="checkbox"/> Laser for Spider Vein        |
| <input type="checkbox"/> Ligation               | <input type="checkbox"/> Ultrasound-Guided Injections |
| <input type="checkbox"/> Other: _____           |   |

What have your results been? \_\_\_\_\_

Any additional History you feel important for us to know? \_\_\_\_\_

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