

OC Vein Care

VENOUS HEALTH HISTORY FORM

Confidential patient information

Patient Name: _____

Date: _____

Date of Birth: _____

Reason for visit:

Referring Physician/Primary Care Provider: _____

1. Have you ever been treated for your veins before? Yes No

If yes, please list what kind of treatment :

Sclerotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vein stripping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laser therapy (EVLT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ultrasound guided injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radiofrequency ablation/Closure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phlebectomy (surgical removal of veins)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Who was your treating physician? _____

When were you treated? _____

How would you describe your results from treatment?

2. Have you ever had a blood clot? Yes No

If yes, which leg and when? _____

3. Have you ever had phlebitis? Yes No

If yes, which leg and when? _____

4. Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mother	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brother(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

5. Do you experience any of the following in your legs?

Aching/pain?

Yes During activity or prolong standing Yes No LT/RT leg Both legs

Heaviness?

Yes During activity or prolong standing Yes No LT/RT leg Both legs

Tiredness/fatigue?

Yes During activity or prolong standing Yes No LT/RT leg Both legs

Itching/burning?

Yes During activity or prolong standing Yes No LT/RT leg Both legs

Swollen ankles?

Yes During activity or prolong standing Yes No LT / RT leg Both legs

Leg cramps?

Yes During activity or prolong standing Yes No LT / RT leg Both legs

Restless legs?

Yes During activity or prolong standing Yes No LT / RT leg Both legs

Throbbing?

Yes During activity or prolong standing Yes No LT / RT leg Both legs

6. Have your veins gotten worse in recent months? Yes No

Describe: _____

7. Do you take any medication for pain (i.e., Advil, Motrin) Yes No

If yes, what medication(s) do you take and how many times/mgs per day?

8. How do you relieve your legs discomfort?

Leg elevation Yes No

If yes, how long per day do you elevate and does it provide relief?

Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold compress	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Warm compress	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tylenol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Support stockings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flex/extend legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

9. Do you exercise? Yes No

If yes, what kind of exercise and how often?

Does walking or exercising relieve or worsen your leg discomfort?

10. Do you wear prescription compression stockings? Yes No

If yes, what type and gradient? How long have you worn them?

11. Do you wear light support hose (i.e., Sheer Energy)?

If yes, do they provide relief? Yes No

12. Do you have any problem walking? Yes No
If yes, describe how it interferes with your activities of daily living, which activities?
(worse at night, after standing/sitting long periods or during/ after exercise)

13. What type of work do you do?

How long do you stand (hours per day) at work? _____

At home? _____

Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours) _____

14. Have you ever had an ultrasound on your veins? Yes No
If yes, when and which leg? _____

15. Were you diagnosed with saphenous vein reflux? Yes No

16. Name of referring Physician and how long have you been under his care for treatment of this condition?

17. Do you have any allergies to drugs or sensitivities to tape?
If yes, list drugs or type of tape and reaction:

18. Do you have any current medical conditions you are being treated for?
if yes, please list conditions: _____

19. List all medications you are taking (prescription, non-prescription, herbal medicines etc.) and dose

SOCIAL HISTORY:

20. Do you smoke or consume alcohol?

If yes, how much: _____

Marital Status: married/single/ divorced/widowed

PAST MEDICAL HISTORY:

Do you have a history of:

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Peripheral Vascular disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| TIA (transient ischemic attack) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Carotid disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coronary heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pulmonary embolus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Easy bruising | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart valve disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leg trauma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Cancer Yes No
Type: _____
Other: _____

PAST SURGICAL HISTORY:

Include procedure and year: _____

BLEEDING HISTORY

Aspirin use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coumadin use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Easy bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Review of systems: (circle appropriate symptom)

Constitutional symptoms: Weight loss/gain/night sweats/fever

Skin: Change in skin color/mole/rash

Eyes: Glasses/contacts/change in vision/blurred vision/double vision

Ear, nose, throat and mouth: Ringing in ears/deafness/pain/sinus
discharge/bleeding/hoarseness/discharge

Cardiac: chest pain/shortness of breath/palpitations/fatigue/leg swelling

Respiratory: Sputum production/coughing of blood/pain/cough

Gastrointestinal: Nausea/vomiting/vomiting of blood/indigestion/reflux/painful
swallowing/diarrhea/

constipation/yellow discoloration of skin/tarry stools/bloody stools/change in bowel
habbits

Genitourinary: Kidney/bladder disease/painful urination/decreased stream/bloody urine

Musculoskeletal: bone/joint deformity/limited motion/pain/weakness/trauma

Neurological: weakness/seizure/faints/paralysis/migraine/unsteady
gait/headache/numbness in extremities

Psychological: hallucinations/anxiety/depression/bipolar

Endocrine: thyroid disease/sweating/tremor/change in appetite/constipation

Hematological: Bleeding disorders/thrombophilia/lymph node enlargement

Immunological: immune disorders/immunosuppression

FEMALES:

Last menstrual period: _____

Hormone therapy: _____

Menopause: _____

Last mammogram: _____

Nipple discharge: _____

Lumps: _____

Cyclical pain: _____

Last pelvic examination: _____

Patient Signature:

_____ Date: _____