History & Physical Form

Date: _____

Your Name: _____ Date of Birth: _____ Age: ___ Sex: M F

Primary Physician: _____ Referred By: _____ Self

Who should receive a letter regarding today's visit: Primary Physician Referring Physician Other

How did you find out about us? TV Radio Physician referral Referral from a friend Other_____

History of Present of Present Illness: Please circle all that apply. Rate your pain (1-10)____

Are you experiencing: Painful veins Aching legs Heavy legs Leg/foot cramps Burning/itching in the legs

Leg swelling Restless legs Enlarging Veins Bleeding veins Skin color changes Leg ulcers

Do your symptoms affect daily activity? Yes No

Does it affect your sleep? Yes No aching cramping

Are your symptoms worse with: sitting driving standing working walking cooking shopping

Do you take pain medication for these symptoms? Yes No

Do you elevate your legs to relieve your symptoms? Yes No

Have you been wearing compression hose? Yes No Do compression hose relieve your symptoms? Y N

Are you in a weight loss program? Y N Do you have a history of gastric bypass? Y N

In the past have you had: Phlebitis Blood clots Deep Vein Thrombosis Pulmonary Embolism h/o Miscarriages

Do you have a clotting disorder? Y N

Are you on blood thinners? Y N which one? _____

Occupation:_____ requires: sitting standing

Family history of varicose veins? Y N Who:_____

History of pregnancy? Y N #of pregnancies?_____ Veins worse with pregnancy number____

Previous vein treatments? Y N EVLT Ablations Stripping Phlebectomy Sclerotherapy

If Yes, where & when _____

Medications: Include oral contraceptives, aspirin, Plavix, Coumadin

_____

_____

_____

Allergies: Include iodine, contrast dye, Latex, Shellfish, Eggs

_____

Past Medical History: Please indicate if you have or have had any of the following:(Please Circle)

High blood pressure	High cholesterol	Diabetes	Kidney failure	GI bleeding
Heart disease	Cancer	Lung disease	Stroke	Heart defect
Peripheral Artery disease	COPD/ Emphysema	Neuropathy	DVT	Details/other:

Past Surgical History: Please indicate if you have had any of the following: (Please Circle)

Heart Bypass	Hernia repair	Carotid artery surgery	Gall Bladder removal	Bowel surgery
Hip replacement	Knee replacement	Fractures	Gastric Bypass	Hysterectomy

Family History: Has anyone in your family ever had: (Please Circle)

Father: cancer, diabetes, hypertension, heart problems, aneurysms, stroke, varicose veins

Mother: cancer, diabetes, hypertension, heart problems, aneurysms, stroke, varicose veins

Bro/Sis: cancer, diabetes, hypertension, heart problems, aneurysms, stroke, varicose veins

Social History: Occupation: _____

Smoke Yes No Packs per day? ___ Years? ___ Quit? ___ When: _____

Drink Alcohol Yes No If yes how much: _____

Are you: Married____ Single_____ Divorced_____ Live alone_____

Review of Systems: Please indicate if you have any of the problems listed below:

General:
Fever or chills
Night sweats
Loss of appetite
Fatigue
Weight Loss or Gain
Eyes:
Glasses or contact lenses
Blurred or double vision
Visual loss
Pain
Redness
Ears, Nose, Mouth, Throat:
Hearing loss
Ear pain
Ringing in ears
Sinus congestion
Frequent nose bleeds
Hoarseness
Difficulty swallowing
Cardiovascular:
Chest Pain
Palpitations
Heart murmur
Heart attack
Pacemaker
Congestive heart failure
Stroke
Leg swelling
Respiratory:
Chronic cough
Shortness of breath
Wheezing
Emphysema
Asthma

Gastrointestinal:
Heartburn/reflux
Nausea/vomiting
Vomiting blood
Bloody/black stool
Stomach or duodenal ulcers
Hepatitis
Liver disease
Genitourinary:
Frequent urination
Painful urination
Blood in urine
Kidney disease or failure
Musculoskeletal:
Joint pain or stiffness
Joint swelling
Joint replacement
Back pain
Leg pain with walking
Muscle weakness
Skin and Breast:
Rash
Sores/ulcers
Dry skin
Itching
Allergic/ Immunologic:
Food allergies
Allergy to iodine or IVP dye
Allergy to local anesthetic
Allergy to penicillin/other antibiotics
Reaction to general anesthesia

Neurological:
frequent headaches
Numbness/tingling
Seizures
Head Injury
Stroke
Migraine headaches
Dizziness
Psychiatric:
Anxiety
Depression
Insomnia
Drug abuse
Alcohol abuse
Endocrine:
Diabetes
Thyroid problems/goiter
Heat or cold intolerance
Hematologic/lymphatic:
Easy bruising
Easy bleeding
Anemia
AIDS or HIV positive
Gynecological:
Irregular or heavy periods
Bleeding between periods
Menopause

NONE OF THE ABOVE

Patient Signature: _____ Date: _____
Physician Signature: _____ Date: _____

Who do you know that would appreciate information about varicose veins or treatment of vein disease?

Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____
Name: _____ Phone: _____ Email: _____