VEIN NEVADA
MINIMALLY | INVASIVE | VEIN | INSTITUTE

Patient Name: ____ Date of Birth: ______________________

Primary Care Doctor: ____

Referring Physician: ____

Pharmacy: ____ Pharmacy Phone: (______) _____-________

Vascular History

Place an "x" if you have any of the following visible findings:

☐ Red/purple spider veins ☐ Bulging veins ☐ Skin discoloration below knee
☐ Leg ulcers/Open wounds ☐ Abdominal veins ☐ Swelling of the lower leg/ankle
☐ Other: ____

Years with varicose veins/spider veins_______
Years with venous ulcers/open wounds_______

Place an "x" if you experience any of the following symptoms in your legs:

☐ Ache or hurt ☐ Swelling ☐ Itching
☐ Become restless at night ☐ Heaviness ☐ Pelvic Pain
☐ Ankle/calf skin changes ☐ Cramping ☐ Tired/Fatigued Legs
☐ Bleeding from veins ☐ Burning ☐ Other __________________

Please check any factors that **aggravate** your leg discomfort/symptoms:

☐ Prolonged standing ☐ Exercise ☐ Work requirements
☐ Prolonged sitting ☐ Tender to touch ☐ Climbing stairs
☐ Menstrual Cycle ☐ Pregnancy ☐ Other: ____________________

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

☐ Compression hose ☐ Warm soaks/heating pad ☐ Massage
☐ Exercise ☐ Cold packs ☐ Pain medications
☐ Leg elevation ☐ Sitting down ☐ Other: ___________________

Have you ever worn compression stockings? ☐ Yes ☐ No

If you have worn stockings, Stockings prescribed by : ______________________________

When? ____________________ For how long:? ______________________________

Have you been treated for your leg veins before? ☐ Yes ☐ No

By whom? ______________________ When? ______________________

If so, by which of the following methods :

☐ Cosmetic injections ☐ Ultrasound guided injections ☐ Radiofrequency ablation (VNUS)

☐ Laser treatment for spider vein ☐ Vein stripping ☐ Laser catheter ablation (EVLA)

☐ Ambulatory phlebectomy ☐ High ligation

What was the outcome? ____

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

____

Are you currently on or have been prescribed blood thinners? ☐ **Yes** ☐ **No**

If yes, for how long? ______________________

Past Medical History

Place an "x" if you have any of the following medical illnesses:

☐ COPD
☐ HIV or AIDS
☐ Arthritis
☐ Asthma
☐ Patent Foramen Ovale (PFO) (Hole in heart)
☐ Bleeding disorder
☐ Cancer
☐ Pace Maker
☐ Atrial Fibrillation
☐ Blood transfusions
☐ Clot in lungs (PE)
☐ Clot in legs (DVT)
☐ Depression
☐ Diabetes
☐ Dialysis
☐ Heart attack (MI)
☐ High blood pressure
☐ High cholesterol
☐ Stroke
☐ Kidney problems
☐ Lupus
☐ Hepatitis B
☐ Hepatitis C
☐ Thyroid disease
☐ Migraines
☐ ASD/VSD
☐ Peripheral arterial disease
☐ Coronary artery disease

Please list any surgeries that you have had:

Please indicate if you have a **FAMILY** history of varicose or spider veins?

☐ Mother ☐ Father ☐ Maternal Grandmother ☐ Maternal Grandfather
☐ Sister ☐ Brother ☐ Paternal Grandmother ☐ Paternal Grandfather
☐ Daughter ☐ Son

FAMILY history of blood clots? ☐ Yes ☐ No

Females Only

Are you pregnant or planning on becoming pregnant soon? ☐Yes ☐No
Are you currently breastfeeding? ☐Yes ☐No
Do you have more leg discomfort on or around your menstrual cycle? ☐Yes ☐No
Number of Children: ______________

Social History

Occupation: ____
Do your daily activities require prolonged periods of standing/sitting? ☐Yes ☐No
Do your work activities require prolonged periods of standing/sitting? ☐Yes ☐No
Do you now or have your ever used tobacco? ☐Yes, Current Smoker ☐Yes, Former Smoker ☐No
If so, how many packs per week _______ and for how many years? ________
Quit date, if applicable _____ / _____ / _______
Average number of alcoholic beverages per week: ☐ None ☐ 1-5 ☐ 6-10 ☐ 10+

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Review of Systems

Please place an "x" for all that apply

Constitutional: ☐ Fever ☐ Night sweats ☐ Significant weight gain (___ lbs) ☐ Significant weight loss (___ lbs) ☐ Exercise intolerance

Cardiovascular: ☐ Chest pain on exertion ☐ Known heart murmur ☐ Arrhythmia ☐ Deep vein thrombosis ☐ Leg pain with exercise

Respiratory: ☐ Shortness of breath ☐ Difficulty breathing ☐ Nasal congestion

Gastrointestinal: ☐ Abdominal pain ☐ Constipation

Genitourinary: ☐ Incontinence ☐ Difficulty urinating ☐ Increased frequency of urination ☐ Blood in urine ☐ Pelvic pain ☐ Pain with intercourse

Musculoskeletal: ☐ Pain in legs ☐ Swelling of thigh ☐ Swelling of calf ☐ Swelling of ankle ☐ Weakness of legs ☐ Leg Cramps

Skin: ☐ Abnormal mole ☐ Dry skin ☐ Rash ☐ Itching ☐ Jaundice ☐ Non-healing wound ☐ Skin discoloration ☐ Bulging veins ☐ Spider veins ☐ Skin ulcer ☐ Cellulitis

Neurological: ☐ Leg numbness ☐ Leg tingling ☐ Restless legs at night ☐ Restless legs during day ☐ Leg fatigue ☐ Decreased skin sensation in legs

Current Medications ☐ See Provided List	**Dose**	**How Often?**

Medication Allergies ☐ See Provided List	**Reaction**