Patient Name: _____ Age: _____

Primary Care Doctor:_____ Referring Physician:_____

How did you hear about us?
Newspaper ad:_____ Television commercial:_____
Magazine ad: _____ Friend/ Family*:_____
Website_____ Other:_____

Vascular History

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

__Red spider veins __Skin discoloration below knee __Purple veins
__Abdominal veins __Bulging veins __Other:_____
__Leg ulcer __Diagnosed vein disease _____

Years with varicose veins/spider veins_____

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

__Ache or hurt __Become restless __Ankle skin changes
__Ulcers __Swelling __Heaviness
__Cramping __Itching __Pelvic Pain
__Bleeding from veins __Burning __Other_____

Please check any factors that **aggravate** your leg discomfort:
__Prolonged standing __Around Menstrual Cycle __Pregnancy
__Exercise __Tender to touch __Prolonged sitting
__ Other:_____

Please check any methods you have used to **relieve** your leg discomfort:
__No discomfort __Compression hose/wraps __Exercise
__Leg elevation __Warm soaks __Cold packs
__ Other:_____ __Pain medicines __Massage

Have you worn compression stockings? Yes No
If so, Stockings prescribed by:_____When?_____

Have you been treated for your leg veins before? Yes No
By whom? _____When? _____

If so, what method?:
__Cosmetic injections __Ultrasound guided injections
__Radiofrequency closure __Laser catheter ablation
__Laser for spider vein __Ligation
__Unknown __Ambulatory Phlebectomy
__Stripping __Other:_____

What was the outcome? _____

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

Current Medications (no need to list dosage)

Allergies to medications	**Reaction**

Past Medical History

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

__COPD	__Constipation	__DVT or PE
__Patent Foramen Ovale	__Diabetes	__Dialysis
__Heart attack (MI)	__High blood pressure	__High cholesterol
__HIV or AIDS	__Aneurysms	__Arthritis
__Asthma	__Atrial Septal Defect	__Bleeding disorder
__Cancer	__Kidney problems	__Lupus
__Patent ductus Arteriosus	__Seizure	__Thyroid disease

Please list any surgeries that you have had:

Do you have a history in your **FAMILY** of varicose or spider veins?
Describe:
__Mother_____ __Father_____ __Grandparents_____
__Siblings_____ __Children_____

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 period? Yes No

Number of pregnancies_____ Number of miscarriages_____

Social History

Occupation:_____

Do your daily activities require prolonged periods of standing? Yes No

- If yes, what activity requires prolonged periods of standing?_____

Do you now or have your ever used tobacco? Yes No Packs/week_____

- Quit date, if applicable_____

Do you drink alcoholic beverages? Yes No #/week_____