VEIN ENVY

New Patient History Form Please fill form completely.

Name _____
Date _____
Primary Doc_____

I. Vein Health History

Current Age _____
Veins Problematic for _____ **years**

Current Leg Symptoms

☐Aching ☐Swelling
☐Fatigue ☐Itching
☐Burning ☐Throbbing
☐Tingling ☐Bleeding
☐Ulcers ☐Restless Legs
☐Skin Color Change
☐Phlebitis (Vein Inflammation)
☐Leg Heaviness
☐Varicose Veins

Other_____

☐Work ☐Air Travel
☐Leisure Activity ☐Long Car Travel
☐Routine Activity ☐Child Care

Pregnancy History
☐No Pregnancies ☐How many? __
☐First Noticed Veins☐Veins worsened

Blood Clots
☐DVT ☐Both ☐R ☐L
☐Phlebitis ☐Both ☐R ☐L
☐Varicose veins that have bled in the past or clotted

Occupation_____
Prolonged ☐Sitting☐Standing ☐Both

Prior Vein Treatments **Date**
☐Sclerotherapy ☐Both ☐R ☐L ___
☐Laser ☐Both ☐R ☐L ___
☐Stripping ☐Both ☐R ☐L ___
☐Phlebectomy ☐Both ☐R ☐L ___
☐Closure ☐Both ☐R ☐L ___
☐Other _____

II. Conservative Measures Attempted to Control Symptoms

Compression Stocking Use
☐First used_____years ago
☐Use Currently
Strength 15-20 20-30 30-40
☐Used with _____
(ie. Sclero Pregnancy, Surgery, Work)
☐Who Suggested _____
Period of past use ____☐months ☐yrs

Do You Have Symptom Relief with :
Elevation ☐Yes ☐No ☐Partial
Non Steroidal inflammatory drugs (Aspirin, Motril, Tylenol, Excedrin)
☐Yes ☐No☐Partial
I have attempted weight reduction :
☐Yes ☐No ☐Not an issue
I exercise:
☐Daily ☐_____ Times per week
☐Weekly ☐No regular exercise

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III. General Medical History

Medications Strength and Frequency
☐None

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Medication Allergies
☐None ☐Yes
If Yes, to what? Type of Reaction
_____ _____

Prior reaction to Lidocaine, Novacaine, Iodine, or Latex?
☐None ☐Yes
If Yes, to what? Type of Reaction
_____ _____

Past or Current Medical Conditions
☐No other problems
☐High Blood Pressure
☐High Cholesterol
☐Heart Attacks
☐Diabetes
☐History of Cancer
☐Recent Pregnancy

_____
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Surgeries/Dates ☐None
_____
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Family with Varicose Veins
☐ Mother ☐Father
☐ Others_____
☐ Treatments?_____

Social History
Marital Status☐S ☐M ☐D ☐W

Smoking ☐Never ☐Quit __ Yrs ago
☐Yes___Pks/d
Alcohol ☐Never ☐Social ☐Moderate

Review of Systems *(circle if yes)*
Head & Neck ☐No Complaints
Migraines Glasses Sinusitis
Dental
Respiratory ☐No Complaints
Asthma Emphysema Bronchitis
Cardiac ☐No Complaints
Angina Murmur High BP
Gastrointestinal ☐No Complaints
Ulcer Reflux IBD
Diverticulosis
Genitourinary ☐No Complaints
UTIs Frequency
Extremities ☐No other Complaints
Arthritis _____
Neuropsych ☐No Complaints
Anxiety Depression Neuropathy
Endocrine No Complaints
Diabetes
Thyroid_____
Hematological ☐No Complaints
Lupus Clotting Disorder

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