Vein &Vascular Institute

Patient Name:____________________________________ **Age**________ **Birthday** ______________**Visit Date**_____________

Referring/Consulting Doctor: _______________________________ **Referring Doctor Ph.#** _____________________

Primary Care Doctor: _____________________________________

Reason for visit: Please list when condition started, is it better or worse now and what tests/treatments have been done. Any new medication started?

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If here for Spider Vein or Varicose evaluation please fill in areas below and section on Vein Disease – page 2.

If you have **pain** , please describe:

Location:____

Timing: (continuous, occasional, episodic)

____

Duration (min./hrs, a.m./p.m.)___________________________

Quality (ache, sharp, dull, burning, tiredness, cramp, tender, throbbing, numb, stabbing)

____

What make it worse/better:_____________________________

____

Severity (1-10)_______________________________________

PAST MEDICAL HISTORY *LIST ANY OTHER MEDICAL PROBLEMS*

High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No	Collapsed lung	Yes	No
Neuropathy	Yes	No	Emphysema/COPD	Yes	No			
Heart Problems	Yes	No	Cancer	Yes	No			
Heart Attack/MI	Yes	No	Bleeding? Ulcer?	Yes	No	**Other**__________		
Heart Failure / CHF	Yes	No	Aneurysm	Yes	No			
Stroke /CVA/TIA	Yes	No	DVT/Blood Clot	Yes	No			
High Cholesterol	Yes	No	Varicose Veins	Yes	No			

PAST SURGICAL HISTORY Please **Check** and provide dates, list **ALL other types** and **WHEN**:

Heart bypass ______________________

Leg bypass R/L ____________________

Vein Surgery R/L ___________________

Carotid Surgery R/L ________________

Aortic Aneurysm

Hernia Appendix Thyroid Gallbladder

Other____

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____

Has anyone in your family ever had… Bro/Sis	Father	Mother	
Cancer			
Diabetes			
Hypertension			
Heart Problems			
Aneurysms			
Stroke			

Social History:

Alcohol Yes No If yes, how much__________

Tobacco Yes No Stop When? __________

If yes, how much _________________

Do you live alone? Yes No

Work Type

Provide List of **All Medications** and **Dose** you are currently taking - include all natural supplements

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Med Allergies: **Pain Meds:**