ESPINOZA VEIN INSTITUTE
HEALTHY LEGS. A STEP AWAY

New Patient Medical History Form

Patient Information

Full Name: ____

Date of Birth: ____________________ Age: ________ Gender: ______________

PLEASE INDICATE REASON FOR VISIT

1. Symptoms in legs and/or pelvic region (check all that apply):

☐ Heaviness or fatigue in legs, ankles and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Aching or pain in the legs, ankles and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Swelling in the legs, ankles and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Throbbing in the legs, ankles and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Itching or burning in legs, ankles and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Cramps or burning in legs and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Spider veins: LEGS	☐ Left leg	☐ Right leg	☐ Both legs
☐ Skin discoloration/Skin changes (hardening, thickening, or scaling)	☐ Left leg	☐ Right leg	☐ Both legs
☐ DVT	☐ Left leg	☐ Right leg	☐ Both legs
☐ Numbness / tingling in legs and/or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Cold legs or feet	☐ Left leg	☐ Right leg	☐ Both legs
☐ Restless legs	☐ Left leg	☐ Right leg	☐ Both legs
☐ Vein bleeding	☐ Left leg	☐ Right leg	☐ Both legs
☐ Varicose vein (bulging veins):	☐ Left leg	☐ Right leg	☐ Both legs
	☐ Perinium	☐ Vagina	☐ Abdomen

☐ Ulcers or sores on the legs:
☐ Left leg - How long have you had it (in weeks or months) _________________
☐ Right leg - How long have you had it (in weeks or months) _________________

☐ Pelvic pain (please describe)____

☐ Other (please describe): ____

2. Spider and/or surface veins (check all that apply):
☐ Face ☐ Hands ☐ Other (please describe): ______________________________

NOTE: If your visit is related to option 2 above, please complete Sections J and L only

SECTION A:

- When did you first notice these symptoms? ________________________days/wks/mths
- Have your symptoms worsened recently? [ ] Yes [ ] No
- Are your symptoms affecting your daily activities? [ ] Yes [ ] No

  If yes, how? ____

- Do your symptoms occur more often:

  - ☐ In the morning
  - ☐ In the evening
  - ☐ After prolonged standing
  - ☐ After prolonged sitting
  - ☐ My symptoms are consistent throughout the day
  - ☐ Not applicable

- How would you rate your pain/discomfort?

  - ☐ Mild and occurs occasionally
  - ☐ Moderate, occurs daily and interferes with daily activities
  - ☐ Severe, occurs daily and limits regular activities

- Does anything alleviate your symptoms? [ ] Yes [ ] No If yes, what?

  ____

- Does anything worsen your symptoms? [ ] Yes [ ] No If yes, what?

  ____

2. Do you have a history of any of the following? (Check all that apply):

☐ Surgeries or procedures on veins ☐ Blood clots in the legs or lungs ☐ Leg ulcers or open wounds ☐ Trauma or injury to the legs ☐ Skin infections on the legs	☐ Chronic swelling or edema ☐ Diagnosed vascular malformations ☐ History of cellulitis in the legs ☐ Previous use of blood thinners (e.g., warfarin, heparin) ☐ None of the above

3. Have you had any imaging or tests done for your veins? [ ] Yes [ ] No

   If yes, please specify:
   Type of test (e.g., ultrasound, venogram): ___________________________

   Date of test: ______________ Results: _____________________________

SECTION B: CONSERVATIVE THERAPY

1. Have you previously used any **conservative therapy options** for your vein-related issues? (Check all that apply):

   - Compression stockings. [ ] Yes [ ] No. **If yes, please complete i to v. below:**
     i. How long have you been using compression stockings/socks:
     ____________________(*state in no. of months or years*)
     ii. Frequency of use:
       a) Wears hose intermittently
       b) Wears hose most days of the week
       c) Wears hose daily
     iii. What leg did you use it on? [ ] Left [ ] Right [ ] Both
     iv. Did you get any relief ? [ ] Yes [ ] No
     v. What grade of stockings/socks did you use?

☐ 15-20mmHg grade stockings	☐ 30-40mmHg grade stockings
☐ 20-30mmHg grade stockings	☐ I do not know

2. Over-the-counter pain relievers
   - What medication have you tried? E.g. Advil/Motrin:_________________

     ____

   - Did you get any relief [ ] Yes [ ] N

3. Prescription medications (for pain relief ONLY)
   - What medication was prescribed to you?___________________________

     ____

   - Did you get any relief [ ] Yes [ ] N

4. Leg elevation

ESPINOZA VEIN INSTITUTE
HEALTHY LEGS, A STEP AWAY

- ☐ While Sitting
- ☐ When Sleeping
- ☐ Hours per day________________
- ☐ Did you get any relief [ ] Yes [ ] N

5. Exercise
6. Weight loss
7. Avoid prolonged sitting or standing
8. Warm soaks
9. Cold packs/soaks

SECTION C: VEIN HISTORY TREATMENTS

1. Have you previously had any **treatment** for your vein-related issues? (Check all that apply):

1. Laser ablation ☐ Date & Dr.? ________________________ 2. Sclerotherapy ☐ Date & Dr.? _______________________ 3. Radiofrequency ablation ☐ Date & Dr.? ________________________ 4. Ambulatory phlebectomy (**Microsurgery performed in office)** ☐ Date & Dr.? ________________________	5. Vein stripping **(Performed in the hospital)** ☐ Date & Dr.? ________________________ 6. Surgical procedures ☐ Date & Dr.? ________________________ 7. Other: ________________________________ ☐ Date & Dr.? _______________________ ☐ I am not sure

SECTION D: MEDICAL HISTORY

4. Have you been diagnosed with any of the following conditions? (Check all that apply):

☐ A Fib ☐ Anemia ☐ Anxiety ☐ Angina ☐ Aortic Aneurysm ☐ Arthritis ☐ Asthma ☐ Atherosclerosis	☐ Hormone imbalance ☐ Hypertension ☐ Hypothyroidism ☐ Irritable bladder ☐ Irritable bowel ☐ Kidney disease ☐ Liver disease ☐ Lupus ☐ Lymphedema

☐ Blood clotting disorders (e.g., Factor V Leiden, Protein C/S deficiency) ☐ Bronchitis/Emphysema ☐ Cancer ☐ Chronic venous insufficiency ☐ Cirrhosis ☐ Cold sores ☐ COPD ☐ Depression ☐ Deep vein thrombosis (DVT) ☐ Diabetes ☐ Epilepsy ☐ Fibromyalgia ☐ GERD ☐ Giant Cell Arteritis (GCA) ☐ Gout ☐ Heart Attack ☐ Heart Disease ☐ Hemorrhoids ☐ Hepatitis ☐ High Cholesterol ☐ HIV	☐ Migraine headaches ☐ Mitral Valve Prolapse ☐ May Thurner's syndrome ☐ Neuropathy ☐ Osteoarthritis ☐ Osteoporosis ☐ Pacemaker ☐ PAD / Poor circulation ☐ Pelvic Congestion syndrome ☐ Peptic Ulcer disease ☐ Peripheral artery disease ☐ Plantar Fascitis ☐ Pulmonary embolism (PE) ☐ Rheumatoid Arthritis ☐ Spine disease ☐ Seizures ☐ Sleep Apnea ☐ Stroke ☐ Superficial thrombophlebitis ☐ TIA (Mini Stroke) ☐ Other: ________________ ☐ NONE OF THE ABOVE

Have you had any of the following surgeries/procedures (check all that apply):

☐ Abdominal surgery ☐ Ankle surgery ☐ Appendectomy ☐ Back surgery ☐ Biopsy ☐ Breast surgery ☐ Bunionectomy ☐ Carpal Tunnel surgery ☐ Cataract surgery ☐ C-section surgery ☐ CABG ☐ Cholecystectomy ☐ Colectomy ☐ Finger surgery ☐ Foot surgery ☐ Hemorrhoidectomy ☐ Hernia repair ☐ Hip replacement ☐ Hysterectomy	☐ Knee surgery ☐ Knee replacement ☐ Laparoscopic surgery ☐ Liposuction surgery ☐ Lung resection surgery ☐ Neck surgery ☐ Partial hysterectomy ☐ Plastic surgery ☐ Prostate surgery ☐ Rhinoplasty surgery ☐ Shoulder surgery ☐ Skin cancer surgery ☐ Thyroid surgery ☐ Tonsillectomy ☐ Tubiligation ☐ Wrist surgery ☐ OTHER__________________________ ☐ None of the above ____

SECTION E: FAMILY HISTORY

- Do you have a family history of vein-related issues [ ] Yes [ ] No
- If yes, please select the condition(s) and state the affected relative(s):

Family is defined as "Father, Mother, Brother, Sister, Grandmother, Grandfather)

☐ Varicose Veins ____

☐ Ulcers____

☐ Deep Vein Thrombosis____

☐ Pulmonary Embolism____

SECTION F: SOCIAL HISTORY

Lifestyle and Habits

1. Employment status:

☐ Employed full time ☐ Employed part time	☐ Retired ☐ Unemployed

2. Occupation (if applicable) ____________________________________
3. Does your job require prolonged standing or sitting? [ ] Yes [ ] No
4. If yes, how many hours per day? ________________________________
5. Disability:

☐ Deaf or serious difficulty hearing ☐ Blind or serious difficulty seeing / when wearing glasses ☐ Do you have any difficulty concentrating or making decisions [ ] Yes [ ] No	☐ Do you have any difficulty walking or climbing stairs [ ] Yes [ ] No ☐ Do you have any difficulty dressing or bathing [ ] Yes [ ] No ☐ Not applicable

6. Marital status:

☐ Unmarried ☐ Married	☐ Divorced ☐ Widowed

7. Alcohol Use:
    - ☐ No. of drinks ______per day __________per week_________ per month
8. Do you exercise regularly? [ ] Yes [ ] No If yes, what type and frequency?

    ____

    ____

9. Do you frequently wear high heels or tight clothing? [ ] Yes [ ] No

SECTION G FOR FEMALE PATIENTS ONLY:

- Are you currently pregnant? [ ] Yes [ ] No [ ] Unsure
- Number of pregnancies: __________ / [ ] N/A
- How many children do you have: ______________________
- Type of delivery : ☐ Vaginal ☐ C-Section
- Number of miscarriages: _____________ / [ ] N/A
- Have you experienced vein issues during pregnancy? [ ] Yes [ ] No [ ] N/A
- Have you experienced a DVT during pregnancy? [ ] Yes [ ] No [ ] N/A
- Are you currently using hormone replacement therapy or birth control? [ ] Yes [ ] No
- Have you previously used hormone replacement therapy [ ] Yes [ ] No [ ] N/A
- Are you currently using oral birth control? [ ] Yes [ ] No
- Have you previously used oral birth control? [ ] Yes [ ] No [ ] N/A
- Do you experience pelvic discomfort or pain? [ ] Yes [ ] No
    - If yes, please check all that applies:

☐ Pelvic pain ☐ Pelvic pain with intercourse ☐ Pelvic pain with menstruation	☐ Pelvic pain when standing ☐ Pelvic pain when tired ☐ Pelvic pain during pregnancy

- Have you been treated for or have had any of the following?:

☐ Fibroids ☐ Endometriosis ☐ C-Section ☐ Hysterectomy	☐ Oophorectomy ☐ Ovarian cysts ☐ Myomectomy ☐ Uterine Ablation

SECTION H: SMOKING HISTORY:

Please be advised, we are required to submit the following responses to Medicare]

- ☐ Never smoked
- ☐ Former smoker:
  - How long did you smoke regularly? ______________years
  - At what age did you start smoking? _______________years
  - Approximately how many packs per day did you smoke? _________
  - Why did you stop smoking?___________________________________
- ☐ Smoker:

☐ Current everyday smoker	☐ Light tobacco smoker
☐ Current infrequent/light smoker	☐ Heavy tobacco smoker

At what age did you first started smoking?_________________

Approximately how many packs per day do you smoke?________________

Have you ever thought about quitting (circle one)?: YES NO

Are you ready to quit? (circle one): YES NO

☐ Tobacco usage:

☐ Cigarettes	☐ Snuff user
☐ Rolls own cigarettes	☐ Moist powdered tobacco
☐ Chews plug tobacco	☐ Chews loose leaf tobacco
☐ Chews twist tobacco	☐ Chews fine cut tobacco
☐ Chews products containing tobacco	

SECTION I MEDICARE ADVANCED DIRECTIVES:

[**Please be advised, we are required to submit the following responses to Medicare**]:

i. Do you have a living will? [ ] Yes [ ] No

ii. Do you have a power of attorney for your medical affairs? [ ] Yes [ ] No

a. **If no**, do you want more information on obtaining a will or power of attorney for your medical [ ] Yes [ ] No

iii. Fall history:

a. No falls in the last 12 months
b. Less than 2 falls in the last 12 months? [ ] Yes [ ] No
c. 2 or more falls in the last 12 months?[ ] Yes [ ] No
d. Fallen, with injury, in the last 12 months? [ ] Yes [ ] No
e. Other:____

SECTION J: MEDICATIONS AND ALLERGIES

- Are you currently taking any medications? [ ] Yes [ ] No

If yes, please list your medications below **OR provide a complete list to a member of our staff:**

1. Drug: ______________________________ Dose: __________ Frequency: _________________
2. Drug:______________________________ Dose: __________ Frequency: _________________
3. Drug:______________________________ Dose: __________ Frequency: _________________
4. Drug:______________________________ Dose:__________ Frequency: _________________
5. Drug: ______________________________ Dose: __________ Frequency: ________________
6. Drug:______________________________ Dose: __________ Frequency: _________________
7. Drug:______________________________ Dose: __________ Frequency: _________________

8. Drug: ______________________________ Dose: __________ Frequency: ________________

9. Drug:______________________________ Dose: __________ Frequency: _________________

10. Drug:______________________________ Dose: __________ Frequency: _________________

Do you have any allergies (medications, foods, etc.)? [ ] Yes [ ] No

- If yes, please list:

ALLERGY	**REACTION**	**SEVERITY**	**DATE OF LAST KNOWN REACTION**

SECTION K: REVIEW OF SYSTEMS

Please indicate if you are currently experiencing any of the following symptoms:

General ☐ Unexplained weight loss or gain ☐ Fatigue or weakness ☐ Fever or chills	**Cardiovascular** ☐ Chest pain or discomfort ☐ Irregular heartbeat or palpitations ☐ Swelling in the legs, ankles, or feet
Respiratory ☐ Shortness of breath ☐ Chronic cough ☐ Wheezing	**Gastrointestinal** ☐ Abdominal pain or discomfort ☐ Nausea or vomiting ☐ Diarrhea or constipation
Neurological ☐ Numbness or tingling ☐ Headaches or migraines ☐ Dizziness or lightheadedness	**Musculoskeletal** ☐ Joint pain or stiffness ☐ Muscle cramps ☐ Back pain
Skin ☐ Rash or itching ☐ Changes in skin color or texture ☐ Non-healing wounds or ulcers ☐ Easy skin bruising ☐ Hair loss	**Psychological** ☐ Anxiety or stress ☐ Depression ☐ Difficulty sleeping
Eyes ☐ Vision changes or eye discomfort	**Allergic/Immunologic** ☐ Hives ☐ Itching ☐ Rashes ☐ Recurrent infections or illnesses

☐ **NONE OF THE ABOVE**

SECTION L: CONSENT AND SIGNATURE

By signing below, I acknowledge that the information provided is accurate to the best of my knowledge. I understand that this information will be used for diagnostic and treatment purposes.

Patient signature: ____ Date: _______________