

New Patient Medical History Form

Patient: Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Gender: M /F

SECTION A: REASON FOR VISIT

1. Spider and/or surface veins (check all that apply):

Face Hands Other (please describe): _____

NOTE: If your visit is ONLY related to option 1 above, please proceed to Sections J and K.

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

<input type="checkbox"/> Heaviness or fatigue in legs, ankles and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Aching or pain in the legs, ankles and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Swelling in the legs, ankles and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Throbbing in the legs, ankles and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Itching in the legs, ankles and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Cramps or burning in legs and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Spider veins : LEGS	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Skin discoloration / Skin changes (e.g., hardening, thickening, or scaling)	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Darkened or red patches on the skin	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> DVT	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Numbness / tingling in legs and/or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Coldness or temperature changes in the legs or feet	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Restless legs	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Vein bleeding / Unexplained bleeding or bruising	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Varicose vein (bulging veins):	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
	<input type="checkbox"/> Perinium	<input type="checkbox"/> Vagina	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Ulcers or sores on the legs	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Both legs
<input type="checkbox"/> Pelvic pain (please describe):			
<input type="checkbox"/> Other (please describe):			

New Patient Medical History Form

- How long have you been experiencing 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 relieve 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):

<input type="checkbox"/> Surgeries or procedures on veins <input type="checkbox"/> Blood clots in the legs or lungs <input type="checkbox"/> Leg ulcers or open wounds <input type="checkbox"/> Trauma or injury to the legs <input type="checkbox"/> Skin infections on the legs	<input type="checkbox"/> Chronic swelling or edema <input type="checkbox"/> Diagnosed vascular malformations <input type="checkbox"/> History of cellulitis in the legs <input type="checkbox"/> Previous use of blood thinners (e.g., warfarin, heparin) <input type="checkbox"/> 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: _____

New Patient Medical History Form

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?

<input type="checkbox"/> 15-20mmHg grade stockings	<input type="checkbox"/> 30-40mmHg grade stockings
<input type="checkbox"/> 20-30mmHg grade stockings	<input type="checkbox"/> 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

- 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

New Patient Medical History Form

SECTION C: VEIN HISTORY TREATMENTS

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

<input type="checkbox"/> Laser ablation Date & Dr. _____ <input type="checkbox"/> Sclerotherapy Date & Dr. _____ <input type="checkbox"/> Radiofrequency ablation Date & Dr. _____ <input type="checkbox"/> Ambulatory phlebectomy Date & Dr. _____	<input type="checkbox"/> Vein stripping Date & Dr. _____ <input type="checkbox"/> Surgical procedures Date & Dr. _____ <input type="checkbox"/> Other: _____ Date & Dr. _____ <input type="checkbox"/> I am not sure.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

SECTION D: MEDICAL HISTORY

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

<input type="checkbox"/> A Fib <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Angina <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Blood clotting disorders (e.g., Factor V Leiden, Protein C/S deficiency) <input type="checkbox"/> Bronchitis/Emphysema <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic venous insufficiency <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Cold sores <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Deep vein thrombosis (DVT) <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> GERD <input type="checkbox"/> Giant Cell Arteritis (GCA) <input type="checkbox"/> Gout <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Hormone imbalance <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Irritable bladder <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Lupus <input type="checkbox"/> Lymphedema <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> May Thurner's syndrome <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker <input type="checkbox"/> PAD / Poor circulation <input type="checkbox"/> Pelvic Congestion syndrome <input type="checkbox"/> Peptic Ulcer disease <input type="checkbox"/> Peripheral artery disease <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Pulmonary embolism (PE) <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Spine disease <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Superficial thrombophlebitis <input type="checkbox"/> TIA (Mini Stroke) <input type="checkbox"/> Other: _____ <hr style="width: 100%;"/> <input type="checkbox"/> NONE OF THE ABOVE
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

New Patient Medical History Form

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

<input type="checkbox"/> Abdominal surgery <input type="checkbox"/> Ankle surgery <input type="checkbox"/> Appendectomy <input type="checkbox"/> Back surgery <input type="checkbox"/> Biopsy <input type="checkbox"/> Breast surgery <input type="checkbox"/> Bunionectomy <input type="checkbox"/> Carpal Tunnel surgery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> C-section surgery <input type="checkbox"/> CABG <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Colectomy <input type="checkbox"/> Finger surgery <input type="checkbox"/> Foot surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip replacement <input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Knee surgery <input type="checkbox"/> Knee replacement <input type="checkbox"/> Laparoscopic surgery <input type="checkbox"/> Liposuction surgery <input type="checkbox"/> Lung resection surgery <input type="checkbox"/> Neck surgery <input type="checkbox"/> Partial hysterectomy <input type="checkbox"/> Plastic surgery <input type="checkbox"/> Prostate surgery <input type="checkbox"/> Rhinoplasty surgery <input type="checkbox"/> Shoulder surgery <input type="checkbox"/> Skin cancer surgery <input type="checkbox"/> Thyroid surgery <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubiligation <input type="checkbox"/> Wrist surgery <input type="checkbox"/> OTHER _____ <input type="checkbox"/> None of the above
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

SECTION E: FAMILY HISTORY

1. Do you have a family history of vein-related issues [] Yes [] No
2. 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:

<input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed
--------------------------------------------------------------------------------------------	-------------------------------------------------------------------------

2. Occupation (if applicable) _____

New Patient Medical History Form

3. Does your job require prolonged standing or sitting? [] Yes [] No
4. If yes, how many hours per day? _____
5. Do you have any difficulty walking or climbing stairs [] Yes [] No
6. Alcohol Use:
 No. of drinks _____ per day _____ per week _____ per month
7. Do you exercise regularly? [] Yes [] No If yes, what type and frequency?

SECTION G: FOR FEMALE PATIENTS ONLY:

1. Are you currently pregnant? [] Yes [] No [] Unsure
2. Number of pregnancies: _____ / [] N/A
3. How many children do you have: _____
4. Type of delivery : Vaginal C-Section
5. Number of miscarriages: _____ / [] N/A
6. Have you experienced vein issues during pregnancy? [] Yes [] No [] N/A
7. Have you experienced a DVT during pregnancy? [] Yes [] No [] N/A
8. Are you currently using hormone replacement therapy or birth control? [] Yes [] No
9. Have you previously used hormone replacement therapy [] Yes [] No [] N/A
10. Are you currently using oral birth control? [] Yes [] No
11. Have you previously used oral birth control? [] Yes [] No [] N/A
12. Do you experience pelvic discomfort or pain? [] Yes [] No

If yes, please check all that applies:

<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Pelvic pain when standing
<input type="checkbox"/> Pelvic pain with intercourse	<input type="checkbox"/> Pelvic pain when tired
<input type="checkbox"/> Pelvic pain with menstruation	<input type="checkbox"/> Pelvic pain during pregnancy

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

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Oophorectomy
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian cysts
<input type="checkbox"/> C-Section	<input type="checkbox"/> Myomectomy
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Uterine Ablation

New Patient Medical History Form

SECTION H: ALLERGIES

Do you have any allergies (medications, foods, etc.)? Yes No. If yes, please list:

<u>ALLERGY</u>	<u>REACTION</u>	<u>SEVERITY</u>	<u>DATE OF LAST KNOWN REACTION</u>

SECTION I: REVIEW OF SYSTEMS

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

General <ul style="list-style-type: none"> <input type="checkbox"/> Unexplained weight loss or gain <input type="checkbox"/> Fatigue or weakness <input type="checkbox"/> Fever or chills 	Cardiovascular <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Irregular heartbeat or palpitations <input type="checkbox"/> Swelling in the legs, ankles, or feet
Respiratory <ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing 	Gastrointestinal <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain or discomfort <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea or constipation
Neurological <ul style="list-style-type: none"> <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Dizziness or lightheadedness 	Musculoskeletal <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain or stiffness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Back pain
Skin <ul style="list-style-type: none"> <input type="checkbox"/> Rash or itching <input type="checkbox"/> Changes in skin color or texture <input type="checkbox"/> Non-healing wounds or ulcers <input type="checkbox"/> Easy skin bruising <input type="checkbox"/> Hair loss 	Allergic/Immunologic <ul style="list-style-type: none"> <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Recurrent infections or illnesses
Eyes <ul style="list-style-type: none"> <input type="checkbox"/> Vision changes or eye discomfort 	Psychological <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety or stress <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping

NONE OF THE ABOVE

SECTION J: 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: _____