NEW PATIENT FORM

Patient Demographic

Patient Name:
MR#

Clinical Information

Chief Complaint:

Pain Score: Rate your pain 0-10: 0 1 2 3 4 5 6 7 8 9 10 or IMPROVED

HPI: Symptoms: (Circle the one(s) that applies)			
Aching	Awaken at Night	Bleeding from Veins	Burning
Cramping	Difficulty Healing Wounds	Fatigue	Heaviness
Itching	Pain: Mild Moderate or Severe	Restless Leg	Swelling
Ulcers	Varicose Veins	Spider Veins	Skin Discoloration
Other:			

Location of Symptoms: (Circle all that applies)			
Both Legs	**Thigh**: Front, Back, Middle, or Side	**Knee**: Front, Back, Middle, or Side	**In the Leg**: Front, Back, Middle, or Side
	In the Calf: Front, Back, Middle, or Side	**In the Ankle**: Front, Back, Middle, or Side	
Right Leg	**Thigh**: Front, Back, Middle, or Side	**Knee**: Front, Back, Middle, or Side	**In the Leg**: Front, Back, Middle, or Side
	In the Calf: Front, Back, Middle, or Side	**In the Ankle**: Front, Back, Middle, or Side	
Left Leg	**Thigh**: Front, Back, Middle, or Side	**Knee**: Front, Back, Middle, or Side	**In the Leg**: Front, Back, Middle, or Side
	In the Calf: Front, Back, Middle, or Side	**In the Ankle**: Front, Back, Middle, or Side	
Groin: Yes or No			
Buttocks : Yes or No			
Other:			

Symptoms Severity:			
Right Side:	Mild	Moderate	Severe
Left Side:	Mild	Moderate	Severe

Symptom Duration:

How long have symptoms been affecting you? _____

_____

When do your symptoms occur (AM/PM, CONSISTENT, OCCASSIONAL)? _____

_____

Are your symptoms affecting your daily activities – Walking, Working, and/or Daily Chores?_____

_____

Conservative Therapy:

Are you currently wearing compression stockings? _____

_____

If so, how long have you been wearing compression stockings? _____

_____

What is the strength of your compression stockings – Over the Counter or prescribed 20-30 strength?_____

_____

Are you using any other kind of method – (weight reduction, exercise, elevation, ibuprofen, cold and/or warm soak)? _____

_____

Past Family, Medical, Surgical, Vein, Social History

Past Vein History
List the Procedure and Vein Affected:
List any Bleeding and/or Blood Disorders:
Indicate if you have had any blood clots and when:
Indicate if you have had any deep vein thrombosis and when and area:
Indicate if you have had any superficial thrombophlebitis and when and area:
Indicate if you have ever had Leg ulcers and list the location:

Medical History (Circle any that would apply)				
Anemia	Aortic Aneurysm	Arthritis	Asthma	Atherosclerosis
Bronchitis/Emphysema	Cancer	Cirrhosis	Cold Sores	Crohn's Disease
Depression	Diabetes	GERD	Gout	Heart Disease
Hepatitis	HIV	Hormonal Imbalance	Hypothyroidism	Hypertension
Irritable Bowel Syndrome	Kidney Disease	Liver Disease	Spine Disease	Lupus
Lymphedema	Migraine Headaches	Mitral Valve Prolapse	Osteoporosis	Pace Maker
Poor Circulation	Peptic Ulcer Disease	Pulmonary Embolus	Seizures	Stroke
Ulcerative Colitis	Please list additional fields:			

Surgical History (Circle any that would apply and approximate date)				
Appendectomy	Breast Surgery	C-Section	CABG	Cholecystectomy
Colectomy	Hemorrhoidectomy	Hernia Repair	Hip Replacement	Hysterectomy
Knee Replacement	Lung resection	Plastic surgery	Prostate surgery	Skin cancer
Thyroid	Tonsillectomy	Other	Please list additional fields:	

Family History (Circle any that would apply)							
Father		**Alive / Age:**			**Deceased / Date:**		
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Mother		**Alive / Age:**			**Deceased / Date:**		
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Brother		**Alive / Age:**			**Deceased / Date:**		
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Sister		**Alive / Age:**			**Deceased / Date:**		
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Son		**Alive / Age:**			**Deceased / Date:**		
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER

Daughter			**Alive / Age:**			**Deceased / Date:**	
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Additional Siblings: Female or Male			**Alive / Age:**			**Deceased / Date:**	
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER
Additional Children: Female or Male			**Alive / Age:**			**Deceased / Date:**	
Unknown	Varicose Veins	Spider Veins	DVT	Stroke	Blood Disorder	Clotting Disorder	OTHER

Social History (Circle any that would apply)						
Marital Status:	Married	Unmarried	Divorced	Widowed	Divorced Remarried	Widowed Remarried
Number of Children:						
Occupation:	Unemployed	Self Employed	Employed Full Time	Employed Part Time	Retired	Homemaker	OTHER
Alcohol Use (Y/N) If yes indicate number of drinks per day, week, or month:						
Smoking Status:	Smoke Everyday	Smoke Some Days	Heavy Smoker	Light Smoker	Former Smoker Year quit:	Never Smoked

Female History
List the number of pregnancies:
Currently pregnant or planning to be pregnant soon?
Currently breast feeding?
Do you have leg discomfort around your menstrual cycle?

Allergies

Please list any allergies to medications:

Current Medications

Please list any medications you are currently taking:

Medication	Dose	Medication	Dose	Medication	Dose