Date: ___________________

Name:____DOB:____________ Age: ___________

Phone Number (Home or Cell?): **Can we leave a message? No Yes**

Email Address:

Mailing Address:____

____

Preferred method of contact: **Phone** **Email**

Primary Care Physician:________________________Referring Physician:__________________

How did you hear about us?

Which leg is bothering you? Right Left Both

Which of the following symptoms have you been experiencing? (circle all that apply)

Pain	Restless legs
Swelling	Itching
Heaviness	Burning
Fatigue	Loss of leg hair
Throbbing	Changes in skin color of legs
Aching	Leg wounds that heal slowly
Leg swelling with long trips	Spontaneous bleeding in legs
Other (please describe):	

How long have you experienced these symptoms?

Have your symptoms worsened recently? No Yes How long ago?

On your **WORST** day, how bad are your symptoms?

None 1 2 3 4 5 Severe

Describe **specific** ways that your symptoms negatively impact your activities or quality of life:_

____

Do you have symptoms daily? No Yes

Do you take OTC Pain Medication for your symptoms? No Yes Type/Kind: ____________

Do you Elevate your legs to relieve discomfort? No Yes

How often?_____________________________________How long?________________________

Have you EVER worn Support or Compression Stockings? No Yes

How long have you worn them?_________________________Do they provide relief? No Yes

Have you tried conservative therapy to treat your symptoms? Weight loss Exercise

Have you ever had Blood Clots in your legs (DVT)? No Yes Date:________ Leg? R L

How was it treated?____

Are you currently taking blood thinners? No Yes Describe:_________________

Have you ever had Superficial Thrombophlebitis? No Yes Leg? R L When?_________

How was it treated?____

Have you ever had a Vein Ablation procedure? No Yes Leg? R L When?________________
Describe____

Have you ever had Sclerotherapy? No Yes Which leg? R L When?______________

Have you ever had Vein Stripping? No Yes Which leg? R L When?______________

Social History:

Occupation:

Do you spend more time sitting or standing at work?

Do you spend more time sitting or standing at home?

How many pregnancies have you had? ___________ N/A

Do you have family members afflicted with varicose veins? No Yes
Describe:

Do you use any of the following?: No Yes
Tobacco________ Alcohol________ IV Drugs_______

Medical History:

Have you ever had significant injury to your leg? No Yes
Describe____

Have you had a joint replacement? No Yes Describe_________________________________

Do you take prophylactic antibiotics before procedures? No Yes Describe:___________

Do you have a clotting disorder? No Yes Describe:_________________________________

Are you taking birth control pills or hormone therapy? No Yes

Do you have any blood born diseases such as HIV/AIDS or hepatitis? No Yes
Describe:____

Describe any other significant medical problems or surgeries?____________________________
____

Allergies to Medications:

Medication___________________________________ Reaction_______________________
Medication___________________________________ Reaction_______________________
Medication___________________________________ Reaction_______________________

Do you have an allergy to any of the following:
Latex? No Yes
Adhesives? No Yes
Acrylic nails? No Yes

Medications:

Aspirin? No Yes
Drug Dosage
Drug Dosage
Drug Dosage
Drug Dosage