POLARIS
VEIN CENTER

Date: _____
Name: _____ **DOB:** _____ **Age:** _____
Phone Number (Home or Cell?): _____**Can we leave a message?** N/Y
Email Address: _____
Mailing Address: _____
Preferred method of contact: **Phone** **Email**
Primary Care Physician: _____ **Referring Physician:** _____ **n/a**
How did you hear about us? _____

Which leg is bothering you? Right Left Both
Which of the following symptoms have you been experiencing (check all that apply)?

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

How long have you experienced these symptoms? _____
Have your symptoms worsened recently? N/Y 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? N/Y _____
Do you take over the counter Pain Medication for the symptoms in your legs? N/Y
What do you take? _____
Do you Elevate your legs to relieve discomfort? N/Y
How often? _____How long? _____
Have you EVER worn Support or Compression Stockings? N/Y
How long have you worn them? _____
Do they provide relief? N/Y Describe: _____
Have you tried other conservative therapy to treat your symptoms? Weight loss Exercise
Have you ever had Blood Clots in your legs (DVT)? N/Y
Which leg? Right Left When? _____
How was it treated? _____
Are you currently taking blood thinners? N/Y Describe: _____
Have you ever had Superficial Thrombophlebitis? N/Y
Which leg? Right Left When? _____
How was it treated? _____
Are you currently taking blood thinners? N/Y Describe: _____

Have you ever had a Vein Ablation procedure? N/Y Was it effective? _____
Which leg? Right Left When? _____
Describe: _____
Have you ever had Sclerotherapy? N/Y Was is effective? _____
Which leg? Right Left When? _____
Have you ever had Vein Stripping? N/Y Was it effective? _____
Which leg? Right Left When? _____

Social History:
Occupation (or most recent job held): _____
Do you spend more time sitting or standing at work?
Do you spend more time sitting or standing at home?
Marital status: Single Married Divorced
How many pregnancies have you had? _____ N/A
Do you have family members afflicted with varicose veins? N/Y
Describe: _____
Do you use any of the following? ☐Non-smoker ☐Ex-smoker
☐ Current Smoker How many packs per day? ____ ☐ Alcohol ☐IV Drugs

Medical History:
Have you ever had significant injury to your leg: N/Y Describe: _____
Have you had a joint replacement? N/Y Describe: _____
Do you take prophylactic antibiotics before procedures? N/Y Describe: _____
Do you have a clotting disorder? N/Y Describe: _____
Are you taking birth control pills or hormone therapy? N/Y
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? N/Y Adhesives? N/Y Acrylic nails? N/Y

Medications: Aspirin? N/Y
Drug _____ Dosage _____
Drug _____ Dosage _____
Drug _____ Dosage _____
Drug _____ Dosage _____

ROS **(-)** **Please check all CURRENT positive findings**

Constitutional ☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue ☐ Insomnia ☐ Poor appetite ☐ Night sweats ☐
Cardiovascular ☐ Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in legs or feet ☐
Respiratory ☐ Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of TB ☐ Excess sputum production ☐
Skin ☐ Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal ☐ Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐
Psychiatric ☐ Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Neurologic ☐ Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/syncope ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Hem/Lymphatic ☐ Easy bruising ☐ Blood clots ☐ Lymphedema ☐ Prolonged bleeding ☐ Low blood count ☐ Swollen lymph nodes ☐
Allergic/Immun ☐ Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐