ALL AREAS MUST BE FILLED OUT COMPLETELY

Today's Date _____/_____/______ Patient's Name ____

DOB _____/_____/______ Age ___________ Marital Status ________________ Referring MD __________________

Reason for the visit:

____

____

Medical History

Were you ever diagnosed with any of the following? Please check if yes:

□ High Blood Pressure	□ Bleeding Disorders	□ Pulmonary Embolism	□ Neuropathy
□ High Cholesterol	□ Hypothyroidism	□ Heart Attack	□ Aneurysm
□ Arrhythmias	□ Seizure	□ End Stage Renal Disease	□ Kidney Disease
□ Heart Murmur	□ Asthma	□ Varicose Veins	□ Sleep Apnea
□ Diabetes	□ Depression	□ Congestive Heart Failure	□ Cancer: _______________
□ Tuberculosis	□ Anxiety	□ Heart Disease	□ Carotid Artery Disease
□ Hepatitis	□ HIV / AIDS	□ Hernia	□ Peripheral Vascular Disease
□ Deep Vein Thrombosis	□ Stroke	□ Angina	□ Peripheral Arterial
□ Anesthesia Complication	□ Liver Disease	□ COPD	□ Other _________________

Current Medications: Please list current medications, dosages, and frequency. Include non-prescription, occasionally used medication (i.e. Tylenol, Advil, ect.), and vitamins. **If none please put N/A**

Medication Names:	**Dosage and Frequency**:
____	____
____	____
____	____
____	____
____	____
____	____
____	____
____	____
____	____

Medication Allergies: Please list any allergies to medication, latex, anesthesia, or dye and reactions you have to these medications. **If none please put N/A**

Medication Name:	**Reaction to Medication:**
____	____
____	____
____	____

Surgical/Hospitalization History: Please List any surgical procedures or hospital stays along with the month/year.
If none please put N/A

Month/Year	Reason/Procedure
________/________	______________________________
________/________	______________________________
________/________	______________________________
________/________	______________________________
________/________	______________________________
________/________	______________________________

Procedure/Treatment History: Please indicate if you have had any of the following. If yes, provide the date, facility, and explanation on the line provided. ***Please Circle one for each***

Angiogram or Dye Injection	Yes	No	______________________________
Balloon Angioplasty or Stent	Yes	No	______________________________
Vena Cava (IVC) Filter	Yes	No	______________________________
Vascular Ultrasound or CT Scans	Yes	No	______________________________
Sclerotherapy	Yes	No	______________________________
Laser Treatment for Veins	Yes	No	______________________________
Vein Stripping / Ligation	Yes	No	______________________________
VNUS Closure™	Yes	No	______________________________
Worn Support Stockings	Yes	No	______________________________

Are you a **DNR**	YES	NO
Do you have a: **Living Will**	YES	NO
Power of Attorney	YES	NO

Family History: Please check below if any family member(s) has/had any of the following conditions, and indicate the relationship.

- ☐ High Blood Pressure ______________________________
- ☐ Diabetes ______________________________
- ☐ Heart Disease ______________________________
- ☐ High Cholesterol ______________________________
- ☐ Stroke ______________________________
- ☐ Bleeding Disorder ______________________________
- ☐ Tuberculosis ______________________________
- ☐ Hepatitis ______________________________
- ☐ Thyroid Disorder______________________________
- ☐ Aneurysm ______________________________
- ☐ Cancer, indicate type ______________________________
- ☐ Other ______________________________

Social History ***Please Circle one for each***

Smoking Current / Previous / Never Number of years _________ Packs/Day ___________ Year Quit ___________

Alcohol Regular / Moderate / Social / Occasional / Never Drinks/Week ______________________________

Illegal/Recreational Drugs Current / Previous / Never Specify Type ______________________________

Exercise Regular / Occasional / None Type and Frequency ______________________________

Occupation ______________________________ **Living With**______________________________

Review of Systems: Please indicate below if you are CURRENTLY experiencing any of the following symptoms. If yes, explain the circulation and how long you have experienced the symptom. ***Please Circle one for each***

Symptom			
Leg Injury	Yes	No	____________________
Leg Pain with Exertion	Yes	No	____________________
Leg Pain at Rest	Yes	No	____________________
Burning in Legs, Feet, or Toes	Yes	No	____________________
Leg or Foot Numbness	Yes	No	____________________
Non-healing Sores/Ulcers	Yes	No	____________________
Discoloration of Legs/Feet	Yes	No	____________________
Recent Weight Change	Yes	No	____________________
Fever or Chills	Yes	No	____________________
Fatigue	Yes	No	____________________
Blurred or Double Vision	Yes	No	____________________
Spots before Eyes	Yes	No	____________________
Hearing Problems	Yes	No	____________________
Chest Pain	Yes	No	____________________
Difficulty Breathing	Yes	No	____________________
Palpitations	Yes	No	____________________
Shortness of Breath	Yes	No	____________________
Wheezing	Yes	No	____________________
Cough	Yes	No	____________________
Painful Breathing	Yes	No	____________________
Nausea or Vomiting	Yes	No	____________________
Bloody Stool or Urine	Yes	No	____________________
Dizziness	Yes	No	____________________
Headache	Yes	No	____________________
Memory Loss	Yes	No	____________________
Numbness	Yes	No	____________________
Prolonged Bleeding	Yes	No	____________________
Easy Bruising	Yes	No	____________________
Swollen Glands	Yes	No	____________________

Patient Signature ______________________________ Date _______/_______/________