

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Referring MD \_\_\_\_\_

**Reason for the visit:**

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**Medical History**

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Pulmonary Embolism       | <input type="checkbox"/> Neuropathy                  |
| <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Hypothyroidism     | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Aneurysm                    |
| <input type="checkbox"/> Arrhythmias             | <input type="checkbox"/> Seizure            | <input type="checkbox"/> End Stage Renal Disease  | <input type="checkbox"/> Kidney Disease              |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Varicose Veins           | <input type="checkbox"/> Sleep Apnea                 |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Depression         | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Cancer: _____               |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Carotid Artery Disease      |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> HIV / AIDS         | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Deep Vein Thrombosis    | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Angina                   | <input type="checkbox"/> Peripheral Arterial         |
| <input type="checkbox"/> Anesthesia Complication | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> COPD                     | <input type="checkbox"/> 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 <b>DNR</b>	YES	NO	
Do you have a: <b>Living Will</b>	YES	NO	
<b>Power of Attorney</b>	YES	NO	

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

<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Hepatitis _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Thyroid Disorder _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Aneurysm _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Cancer, indicate type _____
<input type="checkbox"/> Bleeding Disorder _____	<input type="checkbox"/> Other _____

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

<b>Smoking</b>	Current / Previous / Never	Number of years _____	Packs/Day _____	Year Quit _____
<b>Alcohol</b>	Regular / Moderate / Social / Occasional / Never	Drinks/Week _____		
<b>Illegal/Recreational Drugs</b>	Current / Previous / Never	Specify Type _____		
<b>Exercise</b>	Regular / Occasional / None	Type and Frequency _____		
<b>Occupation</b> _____	<b>Living With</b> _____			

**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**

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** \_\_\_\_/\_\_\_\_/\_\_\_\_