

Phoenix

Heart | Vein | Vascular

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VENOUS HEALTH & HISTORY FORM

PATIENT INFORMATION

| | | | | | |
|--|----------------------------------|----------------|---|---|---|
| Patient's last name: | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/> |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former name): | Birth date: / / | | Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F |

SYMPTOMS

REASON FOR YOUR VISIT TODAY: _____

NUMBER OF YEARS WITH SYMPTOMS, SPIDER VEINS OR VARICOSE VEINS: _____

Occupation: ☐ PROLONGED SITTING ☐ PROLONGED STANDING

Please check if you have had or currently have any of the following **Symptoms** in your Legs, Ankles or Feet within the past 6 months:

- ☐ Hurt/Pain/Throb/Ache/Burn/Sore ☐ Tired/ Heavy Feeling ☐ Cramping ☐ Other: _____
☐ Leg Swelling / Edema ☐ Itching ☐ Restless Legs ☐ Lymphedema

Please check if you have had or currently have any of the following within the past 6 months:

- ☐ Visible Veins/ Varicose Veins ☐ Sores/ Ulcers Below Knee ☐ Blood Clots in your legs (Superficial) ☐ Blood Clots in your legs (deep)
☐ Skin Color Changes Below Knee ☐ Bleeding from Veins
☐ Cellulitis / Skin infection ☐ Other: _____

Please tell us how your signs and symptoms **Negatively** affect your **daily life and activities**:

EXAMPLES: Unable to: ●work, ●do chores, ●care for family, ●travel, ●use stairs, ●heavy lifting, ●shopping, ●exercise, ●stand up after sitting for some time, ●walking, ●gardening etc...

(Please give us at least **TWO SPECIFIC** examples)

Example 1: _____

Example 2: _____

Example 3: _____

Please tell us about any and all methods you have used to help with the discomfort in your legs:

- | | |
|--|---|
| <input type="checkbox"/> Elevation of Legs <input type="checkbox"/> Exercise: Walking or running <input type="checkbox"/> Use of: Tylenol / Ibuprofen / Advil * (NSAIDS) Duration: <input type="checkbox"/> 3-5 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> Years: _____ <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Use of Support / Compression Stockings/ Socks: * (Medical Grade) <input type="checkbox"/> Given by Physician (Rx) <input type="checkbox"/> Over the counter Duration: <input type="checkbox"/> 3-5 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> Years: _____ Type: <input type="checkbox"/> Panty Hose <input type="checkbox"/> Thigh High <input type="checkbox"/> Knee High Results: <input type="checkbox"/> Minimal relief <input type="checkbox"/> Moderate relief <input type="checkbox"/> Significant relief |
|--|---|

PAST VENOUS MEDICAL HISTORY

- ☐ History of **DVT** (Deep Vein Thrombosis / Blood Clots or Clotting disorder) ☐ History of **PE** (Pulmonary Embolism)
- ☐ Clotting Disorder: ☐ Factor VI Leiden ☐ Prothrombin gene mutation ☐ _____
- ☐ leg Injury ☐ Knee surgery ☐ Hip surgery ☐ other: _____

PREVIOUS VEIN TREATMENTS:

- ☐ Treatment done by: _____ ☐ What Clinic: _____

Treatment Method:

- ☐ Injections (Sclerotherapy) ☐ EVLT (laser procedure for Varicose Veins) ☐ Plebectomy (removal of veins)
- ☐ Laser for Spider Veins ☐ Stripping / Surgery ☐ Stents/ Filters: _____
- ☐ Other: _____

FAMILY VASCULAR MEDICAL HISTORY

- ☐ History of **DVT** (Deep Vein Thrombosis / Blood Clots or Clotting disorder) ☐ History of **PE** (Pulmonary Embolism)
- ☐ History of Varicose Veins / Venous Disease

PAST CARDIOVASCULAR HISTORY

- ☐ History of CHF (Congestive Heart Failure) ☐ High Blood Pressure ☐ Heart Attack
- ☐ Diabetes

MEDICATIONS / ALLERGIES / SURGICAL HISTORY

Please list all **MEDICATIONS** that you are currently taking with dosage: (☐ SEE LIST)

ALLERGIES:

- ☐ (NKDA) No Known Drug Allergies **SKIN ALLERGIES:** ☐ Latex ☐ Skin Tape

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

PAST SURGERIES: (List with dates)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

FOR WOMEN ONLY

- | | |
|---|--|
| <input type="checkbox"/> Date of last menstrual cycle: _____ | <input type="checkbox"/> Number of Pregnancies: _____ |
| <input type="checkbox"/> Trying to become pregnant | <input type="checkbox"/> Number of Miscarriages/ Stillbirths: _____ |
| <input type="checkbox"/> Currently Pregnant (please inform medical staff) | <input type="checkbox"/> Veins on Vulva or Labia |
| <input type="checkbox"/> Breast Feeding | <input type="checkbox"/> Pelvic Pain or Heaviness / Pelvic Congestion Syndrome |
| <input type="checkbox"/> Post Menopausal | <input type="checkbox"/> Hysterectomy/Date: _____ |

SOCIAL HISTORY

- ☐ Caffeine: ☐ Daily ☐ Occasionally ☐ Never
- ☐ Alcohol: ☐ Daily ☐ Socially ☐ Occasionally ☐ Never
- ☐ Smoking: ☐ Daily ☐ Socially ☐ Occasionally ☐ Never ☐ Former: stopped _____