VeinCare Experts

Patient History

Date

PATIENT INFORMATION

Last Name | First Name | M.I. | Date of Birth

Referring Physician | Other Referral

Send pertinent VeinCare records to:

What is the reason for this visit?

Prior vein evaluation or treatment

Compression stocking usage

☐ current for _____ months ☐ prior ☐ prescription ☐ non-prescription ☐ strength (if known) _____

What are your goals/expectations for your treatment?

SYMPTOMS *(check all that apply)*

	LEFT	RIGHT		MADE WORSE BY	IMPROVED BY
Aching/pain			Standing		
Heaviness			Sitting		
Tiredness/fatigue			Warm weather		
Itching/burning			Exercise		
Swelling			Menses		
Leg cramps			Leg elevation		
Leg restlessness			Compression stocking		
Throbbing					
Other _____					

My symptoms impact my

☐ quality of life ☐ ability to perform activities of daily living ☐ ability to perform job duties

MEDICATIONS *(please list all medications, hormones, birth control pills, and supplements, taking by prescription and over the counter)*

Name	Dose	Frequency

ALLERGIES *(please list all allergies to medicines, iodine, foods, or other and the type of reaction)*

continued on reverse side

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SURGICAL HISTORY *(list all operations and dates)*

_____

_____

_____

_____

_____

MEDICAL HISTORY

_____ high blood pressure
_____ heart disease
_____ diabetes
_____ hepatitis or liver disease
_____ HIV
_____ kidney disease
_____ lung disease
_____ cancer
_____ DVT
_____ tobacco usage *(type and frequency)*

_____

Other *(specify)* _____

_____

FAMILY HISTORY

_____ high blood pressure
_____ heart disease
_____ diabetes
_____ varicose veins
_____ DVT
_____ cancer *(specify)* _____

Other *(specify)* _____

Do you take ☐ doxycycline ☐ nitrofurantoin ☐ blood thinners(specify)

If you are a woman

_____ Number of pregnancies
_____ Number of deliveries
_____ I am pregnant or actively trying to become pregnant
_____ I take birth control pills
_____ I take hormone replacement therapy
_____ I am breastfeeding

REVIEW OF SYSTEMS *(indicate if you have symptoms in any of the following categories)*

General
_____ unexplained weight loss
_____ night sweats
_____ fatigue
_____ loss of appetite
_____ fevers
_____ easy bruisability

Eyes, Ears, Nose, Throat
_____ visual changes
_____ headaches
_____ frequent nose bleeds
_____ pain with swallowing
_____ sore throat

Cardio/Respiratory
_____ chest pain
_____ shortness of breath
_____ cough or wheeze
_____ leg pain/cramps limiting walking

Gastrointestinal
_____ abdominal pain
_____ difficulty swallowing
_____ indigestion
_____ nausea/vomiting
_____ constipation/diarrhea
_____ rectal bleeding

Genitourinary
_____ painful urination
_____ blood in urine
_____ difficult urination
_____ abnormal periods *(women)*
_____ sexual dysfunction

Musculoskeletal
_____ muscle/joint pain
_____ arthritis
_____ joint swelling

Neurological
_____ change in sight,abnormal smell, hearing, taste
_____ seizures
_____ dizziness
_____ poor balance
_____ numbness/tingling
_____ abnormal speech
_____ migraine headaches

Psychiatric
_____ depression
_____ anxiety

Skin
_____ rashes
_____ itching
_____ skin lesions