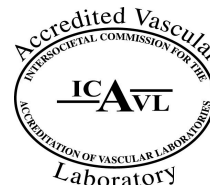




*A center exclusively for the treatment of varicose and spider veins*



Lori L. Greenwald, MD, FACS  
Medical Director

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient History Form**

Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Referred by: (please tell us their name) \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_

Ad (where) \_\_\_\_\_ Friend \_\_\_\_\_ Other (please specify) \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

**Please complete the following questionnaire, trying not to leave any blank spaces.**  
**The more information we have, the better we can care for you.**

Reason for consultation: Right leg \_\_\_\_\_ Left leg \_\_\_\_\_ Both \_\_\_\_\_

**Vascular History**

**How old were you when you first noticed your varicose veins?** \_\_\_\_\_

**Do you have or have you ever been diagnosed with any of the following?**

Varicose vein problems	Yes	No	R__	L__
Phlebitis (redness/tenderness of vein)	Yes	No	R__	L__
Blood clots	Yes	No	R__	L__
Deep vein thrombosis (DVT)	Yes	No	R__	L__
Saphenous vein reflux	Yes	No	R__	L__

**Please Explain:**

**Do you experience any of the following in your leg(s)?**

Aching	Yes	No	R__	L__
Throbbing	Yes	No	R__	L__
Pain (sharp/stabbing)	Yes	No	R__	L__
Heaviness	Yes	No	R__	L__
Tiredness/fatigue	Yes	No	R__	L__
Itching	Yes	No	R__	L__
Burning	Yes	No	R__	L__
Ankle Swelling	Yes	No	R__	L__
Vein swelling	Yes	No	R__	L__
Restless legs	Yes	No	R__	L__
Night cramps	Yes	No	R__	L__
Skin discoloration	Yes	No	R__	L__
Ulcers	Yes	No	R__	L__
Bleeding varicosities	Yes	No	R__	L__
Have your veins gotten worse in recent months?	Yes	No	R__	L__

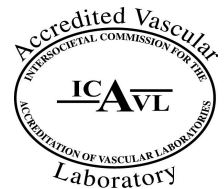
**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Are your symptoms worse with any of the following?**

Prolonged sitting	Yes	No
Prolonged standing	Yes	No
Walking	Yes	No
Climbing stairs	Yes	No
Exercise	Yes	No
Heat	Yes	No



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**Which of the following do you do to treat your leg symptoms:**

Medication Yes No Name: \_\_\_\_\_ How often ?  
Elevation of the legs Yes No How long: \_\_\_\_\_ and how many times a day?  
Wear support hose Yes No Type: \_\_\_\_\_ for how long

Which of the above treatments help? \_\_\_\_\_

**Have you seen any physician in the past for your varicose veins?**

**Please provide any documentation of past symptomatic treatments? (i.e. prescription for compression hose, PCP office notes, ObGYN notes, etc.)**

**Vein Treatment History**

Have you ever been treated for varicose veins with the following: By Whom? \_\_\_\_\_

Sclerotherapy (varicose/spider vein injections) Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_  
Laser therapy Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_  
Phlebectomy Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_  
Vein stripping surgery Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_  
Vein Ablation Procedure Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_  
Compression stockings Yes No R \_\_\_ L \_\_\_ Date: \_\_\_\_\_

**WOMEN ONLY (Please answer the following):**

1. Is there a chance you are currently pregnant? Yes No N/A  
2. # of pregnancies: \_\_\_\_\_ # of children: \_\_\_\_\_ ages: \_\_\_\_\_  
3. Have your veins gotten worse with pregnancy? Yes No  
4. Are you currently breast feeding? Yes No N/A  
5. Are your symptoms worse with menses? Yes No N/A  
6. Are your symptoms worse with menopause? Yes No N/A  
7. Do you take birth control pills? Yes No N/A  
8. Do you use hormone replacement therapy? Yes No N/A

**Past Medical History (Please circle the appropriate answer)**

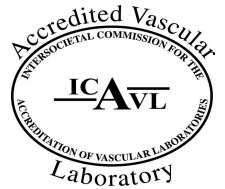
1. Previous Hospitalizations Yes No  
If yes, reason for hospitalization. \_\_\_\_\_  
2. Surgeries? Yes No  
If yes, what type of surgery and when? \_\_\_\_\_  
3. Are you presently under the care of a physician? Yes No  
If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History** Do you have a history of any of the following?

Heart disease/heart attack/stress test Yes No Cancer Yes No  
Mitral valve prolapse Yes No Thyroid Yes No  
High blood pressure Yes No Fear of Needles Yes No  
Elevated cholesterol Yes No History of fainting Yes No  
Lung disease/asthma/bronchitis/emphysema Yes No Blood Disorder Yes No  
Tuberculosis (TB) Yes No Clotting/Bleeding Disorder Yes No  
Diabetes Yes No Anemia Yes No  
Liver disease/hepatitis Yes No HIV/AIDS Yes No  
Kidney disease Yes No Blood Transfusions Yes No  
Osteoporosis Yes No Tattoos Yes No  
Asthma Yes No Migraines and or Ocular Migraines Yes No Explain \_\_\_\_\_  
Lactose Intolerant Yes No



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**Review Of Symptoms** Do you ever experience any of the following?

Chest pain	Yes	No	Knee/Hip pain	Yes	No
Shortness of breath	Yes	No	Back Pain	Yes	No
Palpitations	Yes	No	Keloid/Excessive scarring	Yes	No
Irregular heart beat	Yes	No	Sudden weight loss or gain	Yes	No
Low blood pressure	Yes	No	Visual Problems	Yes	No
Seizures	Yes	No	Depression/Memory Loss	Yes	No

If you have answered yes to any of the above, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently under a physician's care for any of the above? Yes No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

**Family History**

Do any of your family members have the following?

Varicose veins	Yes	No	Who? _____
Vein stripping	Yes	No	_____
Blood clots/pulmonary embolism	Yes	No	_____
Blood coagulation disorder	Yes	No	_____
Heart disease/heart attack	Yes	No	_____
Stroke	Yes	No	_____

**Social History**

Do you exercise regularly? Yes No

Type of exercise: \_\_\_\_\_

Do you smoke? Yes No Amount: \_\_\_\_\_

Do you drink alcohol? Yes No Amount: \_\_\_\_\_

Do you lift heavy objects? Yes No Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Does your work require any of the following: Yes No

Prolonged standing periods Yes No

Prolonged sitting periods Yes No

Lifting more than 15 pounds on a regular basis Yes No

**Medications :**

(Please list all types including herbals, vitamin K, and over the counter medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

