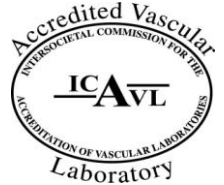




A center exclusively for the treatment of varicose and spider veins



Lori L. Greenwald, MD, FACS
Medical Director

Patient History Form

Name: _____ Age: _____ Date: _____ 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)?

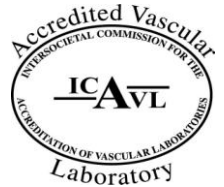
Aching	Yes	No	R	L
Throbbing	Yes	No	R	L
Pain (sharp/stabbing)	Yes	No	R	L
Heaviness	Yes	No	R	L
Tiredness/fatigue	Yes	No	R	L
Itching	Yes	No	R	L
Burning	Yes	No	R	L
Ankle Swelling	Yes	No	R	L
Vein swelling	Yes	No	R	L
Restless legs	Yes	No	R	L
Night cramps	Yes	No	R	L
Skin discoloration	Yes	No	R	L
Ulcers	Yes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

Height _____ **Weight** _____

Patient name: _____



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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 |

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, Oby GYn 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 |

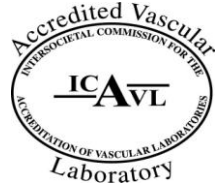
Past Medical History (Please circle the appropriate answer)

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. _____
- _____
- _____

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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			
Osteoporosis	Yes	No			

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	_____

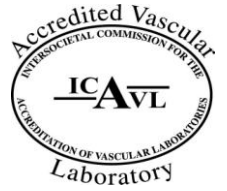
Social History

Do your symptoms interfere with your daily activities?	Yes	No	
How? _____			
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	

Patient name: _____



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