Date:_____

Name (include Middle Initial): _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

DOB:_____ **SSN:**_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Email:_____

Insurance:_____

Occupation:_____ Fulltime Part-time Retired Disabled

Employer:_____ **Phone:**_____

Martial Status:_____ **Full Name of Spouse:**_____

Spouse DOB:_____ **Spouse Employer:**_____

Emergency Contact:_____**Phone #:**_____

Primary Doctor:_____

Would you like us to send copies of your clinical information to your primary doctor? Y/N

How did you hear about us?_____

My symptoms include:

☐ Varicose veins __L __R

☐ Leg discomfort __L __R

aching	burning	dull
sharp	radiating	shooting
itching	tingling	throbbing

☐ muscle cramping	__L __R	☐ heaviness	__L __R
☐ fatigue/weakness	__L __R	☐ skin hard/tough	__L __R
☐ skin discoloration (tan)	__L __R	☐ dryness/flaking	__L __R
☐ edema/swelling	__L __R	☐ ulcers/wounds	__L __R
☐ leg restlessness	__L __R	☐ blood clots	__L __R
☐ inflammation/redness	__L __R	☐ bleeding	__L __R

My symptoms interfere with the following activities:

☐ working	☐ standing long periods	☐ sitting long periods
☐ shopping	☐ household chores	☐ sleeping
☐ lawn care	☐ childcare, eldercare	☐ driving
☐ walking	☐ exercise	☐ _____

To relieve discomfort, I have tried:

☐ regular exercise, such as walking	☐ weight reduction
☐ elevating legs	☐ limiting salt intake
☐ wearing nonconstrictive clothing	☐ avoid standing for long periods of time

☐ over the counter analgesics: Tylenol

☐ compression stockings: knee high / thigh high compression:_____

Prescribed By:_____ when?:_____

Do you wear them consistently? Y / N How long?:_____

Prior Medical Treatment or Testing:

☐ Sclerotherapy_____ ☐ Laser Ablation_____

☐ Vein Stripping_____ ☐ Ultrasound_____

Any other information:

_____

_____

_____

_____

Cardiac/Vascular • Heart disease • Slow/Fast heartbeat • High blood pressure • High cholesterol • Pacemaker/Defibrillator	• Heart attack • Vlave problem/murmur • CHF • Perifpheral Vascular Disease	Comments/Surgeries:
Neurology • Dizzieness/Fainting • Migraines • Stroke/TIA • Paralysis	• Numbness/tingling • Vision problems • Seizures • Speech problems	Comments/Surgeries:
Respiratory • Cough/wheezing • Shorness of breath • COPD/emphysema • Sleep Apnea	• Bronchitis • Asthma • Pneumonia • Sinusitis	Comments/Surgeries:
Musculoskeletal • Arthritis type:_____ • Osteoporosis • Cane/Walker/WC	Renal/Endocrine • Kidney problems • Dialysis HD/CPD • Diabetes I/II	Comments/Surgeries:

• Injuries	• Thyroid Problems	
<u>Gastrointestial</u> • Stomach ulcers • Heartburn/GERD • Nausia/vomitinig • Diarrhea/constipation	<u>Genitourinary</u> • Pain/burning • Frequent Infections • Prostate problems • Incontinence	Comments/Surgeries:
<u>Mental Health</u> • Depression • Anxiety • Bipolar disorder • Addictions	<u>General</u> • Rash/skin problems • Bruising easily • Fevers/chills • Weight loss/ gain	<u>Reproductive</u> • Pregnancies__ Births__ • Surgeries • Last Menstrual Cycle • Peri/Post-Menopausal

Family History

Father	Age:	Alive/Expired	CAD	DM	HTN	
Mother	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	
Brother/Sister	Age:	Alive/Expired	CAD	DM	HTN	

<u>Allergies</u>_____ Specifically IVP dye, Shellfish, Latex, Valium, or any drug in the “caine” family

Medications, Food, Latex, or Environmental	**Reation**

Medications Please include all supplements and over the counter medications

Name	Dose	Frequency	Used to Treat

Please Bring Your Medication With You To The Office

Social History

- Do you smoke? Y/N ____pk per day/week for _____yrs. Quit - When? _____
- Drink any alcohol? Y/N____drinks _____times per week/month/year
- Illicit drug use? Y/N Type_____ Last used - _____
- Drink any caffeinated beverages? Y/N _____ cups per day/week Coffee/Tea/Soda
- Occupation:_____FT/PT Sudent/ Disabled/ Retired
- Marital Status: M /W / S / D Can we share your medical informations with your spouse? Y/N
- Diet: Regular Low Salt Low fat Low cholesterol ADA

  other:_____
- Exercise: Never Rarely Occasionally Regularly→____days per week for at least____min.
  Type of exercise: _____