Varicose Vein Treatment

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____Primary Care Physician: _____

MEDICAL HISTORY

How did you hear about Diversified Vein Treatment? _____

What is the reason for this visit? _____

When did the problem start? _____

When do the symptoms occur? _____

How long do the symptoms last? _____

Do you experience any problems walking or exercising? _____

Are your symptoms worse at the end of the day or in the morning? _____

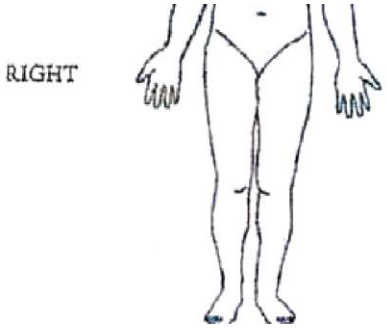
What relieves the symptoms? _____

Do your symptoms interfere with your lifestyle? _____

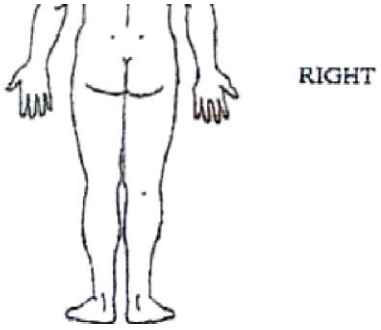
What are the symptoms?

Aching/Pain	[ ] Yes [ ] No	[ ] RT [ ] LT
Heaviness	[ ] Yes [ ] No	[ ] RT [ ] LT
Tiredness/Fatigue	[ ] Yes [ ] No	[ ] RT [ ] LT
Itching/Burning	[ ] Yes [ ] No	[ ] RT [ ] LT
Swollen Ankles	[ ] Yes [ ] No	[ ] RT [ ] LT
Leg Cramps	[ ] Yes [ ] No	[ ] RT [ ] LT
Throbbing	[ ] Yes [ ] No	[ ] RT [ ] LT
Restless Legs	[ ] Yes [ ] No	[ ] RT [ ] LT

Where is your pain now?



Mark the areas on your body where you feel your symptoms:



Have you had any diagnostic tests (labs, ultrasound, sclerotherapy) for your veins? _____

_____

_____

When was your last check up / physical exam? _____

Patient _____Date_____

PLEASE LIST ANY PAST SURGERIES AND DATES:

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY OTHER MEDICAL ILLNESSES AND/OR HOSPITALIZATIONS:

_____ _____

_____ _____

LIST ALL MEDICATIONS/HERBAL SUPPLEMENTS/ALTERNATIVE AND TREATMENTS YOU ARE TAKING:
(Including over the counter, prescribed meds, steroids, inhalers, or drugs including aspirin)

MEDICATION	**DOSE # PER DAY**	**/FREQUENCY**	**REASON FOR TAKING**

ARE YOU ALLERGIC TO ANY MEDICATIONS? [ ] yes [ ] no **List ALL med allergies and type of reactions:**

_____ _____

_____ _____

_____ _____

DO YOU HAVE A LATEX ALLERGY? YES ☐ NO ☐ DO YOU HAVE SEASONAL ALLERGIES? YES ☐ NO ☐

DO YOU TAKE ANY BLOOD THINNERS: YES ☐ NO ☐ COUMADIN ☐ ASPIRIN ☐ dose_____

ADVIL / ANTI-INFLAMMATORY MEDS ☐ OTHER: _____

ALCOHOL USE: Do you drink? YES ☐ NO ☐ Never ☐ Occasional ☐ Daily ☐ # of Drinks per Week: _____

TOBACCO USE: Do you smoke? YES ☐ NO ☐ Packs Per Day: _____ For How Many Years? _____ Date Quit: ____

Do you Chew Tobacco? YES ☐ NO ☐ RECREATIONAL **DRUG USE**: Do you use? YES ☐ NO ☐

MARITAL **STATUS:** Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT? Yes ☐ No ☐ N/A ☐

Number of Children: _____

Occupation: _____ Retired? Yes ☐ No ☐

Patient _____Date_____

FAMILY HEALTH HISTORY:

Father: Age_____ Living [ ] Deceased [ ] Cause of Death or illness_____ Mother: Age_____ Living [ ] Deceased [ ] Cause of Death or illness_____ Brother(s): Age_____ Living [ ] Deceased [ ] Cause of Death or illness_____ Sister(s) Age_____ Living [ ] Deceased [ ] Cause of Death or illness_____ Children Age_____ Living [ ] Deceased [ ] Cause of Death or illness_____ Other_____

Please list family history of vein problems and how treated: _____

_____

_____

Review of Systems: (*Please circle any problems or symptom you have had or currently have)*
General: Recent illness, fever, chills, night sweats, weight loss/gain.
Skin: Bruising/bleeding disorders, rashes, itching, skin cancer, other disease of the skin _____.
Cardiovascular: Shortness of breath, palpitations, chest pain, swelling in extremities, murmur, angina.
Respiratory: Chronic cough, wheezing, pain with breathing, productive cough.
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice.
Genitourinary: Blood in urine, difficulty controlling bowel/bladder, urinary frequency/urgency or burning.
Neurological: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness.
Musculoskeletal: Joint pain, tingling, burning, backache, neck ache, fatigue.
Psychological: Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep.

*******************Physician office to complete remainder of medical info******************

[ ] Prior Conservative treatment history:_____

_____

_____

_____

[ ] Formal Ultrasound_____

_____

[ ] In Office Limited Venous Duplex [ ] Right [ ] Left [ ] Bilateral

_____

_____

_____

_____

_____

_____

Physical Exam

Height _____ Weight _____ V/S Temp _____ Respirations_____

B/P_____ Pulse _____ SAO2% _____

Measurements RLE_____

Visual Exam RLE_____

_____

_____

_____

Measurements LLE_____

Visual Exam LLE_____

_____

_____

_____

TESTS DATE FACILITY INTERPRETATION

CEAP Clinical Classifications:

0 - Asymptomatic. No visible or palpable signs of venous disease
1 - Spider veins, reticular veins, Telangiectasias
2 - Varicose veins
3 - Edema
4 - Skin changes
5 - Healed ulcer
6 - Active ulcer

Patient has Class: _____

Recommendation of the following procedure(s)

- ☐ Endovenous ablation- RFA of GSV [R] [L]
- ☐ Endovenous ablation- RFA of SSV [R] [L]
- ☐ Endovenous ablation- RFA perf or trib. [R] [L]
- ☐ Sclerotherapy [R] [L]
- ☐ Ultrasound Guided Sclerotherapy [R] [L]
- ☐ Stab Phlebectomy [R] [L]
- ☐ Other: _____

Physician Comments: _____

_____

_____

_____

_____