



VARICOSE TO PERFECT

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## CONFIDENTIAL HEALTH & VASCULAR HISTORY

### PATIENT INFORMATION

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

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Years with varicose / spider veins? \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

TV \_\_\_\_\_ RADIO \_\_\_\_\_ Other: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

### PRIMARY CARE INFORMATION

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

### SYMPTOMS

Please check if you have:

Red spider veins	Bulging veins
Skin discoloration below your knee	Flat bluish-green veins
Purple veins	Diagnosis of vein disease
Purple vein network	Leg ulcer
Abdominal veins	Leg ulcer
Other: _____	

Do your legs or ankles:

Ache or hurt?	Please describe	_____
Swell?	Please describe	_____
Cramp?	Please describe	_____
Become restless?	Please describe	_____
Become tired / heavy?	Please describe	_____
Itch?	Please describe	_____
Other?	Please describe	_____

### MEDICAL HISTORY

Is there a history in your **FAMILY** of spider or varicose veins?

Describe which:

Mother _____	Siblings _____
Father _____	Aunt/Uncle _____
Grandparents _____	Child _____

Is there a history in your **FAMILY** of deep venous thrombosis, stroke or clotting disorders?

Describe which:

Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Grandparents \_\_\_\_\_

Siblings \_\_\_\_\_  
Aunt/Uncle \_\_\_\_\_  
Child \_\_\_\_\_

Do **YOU** have a history of:

Anemia  
Ankle Skin changes  
Atherosclerosis  
Bleeding/Blood disorder  
Chest pain discomfort  
Constipation  
Crohn's disease, IBS  
Deep Vein Thrombosis/clot  
Diabetes; Insulin dependent  
Easy bruising  
HIV  
Heart disease  
Hepatitis

Hypertension  
Kidney disease  
Leg ulcers  
Liver Disease  
Lupus  
Migraine Headaches  
Mitral valve prolapse  
Pulmonary embolus  
Rupture of a vein  
Superficial Thrombophlebitis  
Trauma to your legs  
Other \_\_\_\_\_

### **CURRENT MEDICAL INFORMATION**

Do you have allergies or sensitivities to medicines or tape? List all: \_\_\_\_\_

Are you being treated for any illnesses or conditions? \_\_\_\_\_ If so, what illness: \_\_\_\_\_

\_\_\_\_\_  
Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

### **VASCULAR HISTORY**

Please check any methods you have used to relieve your leg discomfort:

No Discomfort	Warms Soaks
Leg Elevation	Cold Packs
Exercise	Pain Meds
Flexion/Extension of your feet	Aspirin
Walking	Tylenol
Support Hose	Ibuprofen
Wraps	Other Methods:

Are you on your feet for long periods? \_\_\_\_\_ In what capacity? \_\_\_\_\_

Does walking/exercise relieve your discomfort or make it worse? \_\_\_\_\_

**For Women:**

**Are you pregnant** or planning to be soon? \_\_\_\_\_ Are you currently breast feeding? \_\_\_\_\_

Do you have discomfort around your menses? \_\_\_\_\_

No. of pregnancies thus far? \_\_\_\_\_ Number of still birth / miscarriages? \_\_\_\_\_

Have you been treated for your veins before? \_\_\_\_\_

By whom? \_\_\_\_\_ When? \_\_\_\_\_

What method?

Cosmetic Injections

Stripping

Ambulatory Phlebectomy

Ligation

Other \_\_\_\_\_

Ultrasound-Guided Injections

Radiofrequency Closure

Laser Catheter Ablation

Laser for Spider Veins

What have your results been? \_\_\_\_\_

\_\_\_\_\_

What about your legs would you now most like to correct? \_\_\_\_\_

Patient Signature : \_\_\_\_\_ Date \_\_\_\_\_