Columbus Vein Center

Today's Date:____________________ Phone Number:____

Name ____ DOB _____________Age_________

Email ____

Who is your Primary Care Physician? ____

Who is your Referring Physician? ____

How did you hear about us?____

Which leg is bothering you? ☐ Left ☐ Right ☐ Both

Which of the following symptoms have you been experiencing (check all that apply)

- ☐ Swelling
- ☐ Pain
- ☐ Itching
- ☐ Burning
- ☐ Heaviness
- ☐ Aching
- ☐ Other (please describe): ____
- ☐ Fatigue
- ☐ "Restless" legs
- ☐ Skin/hair changes
- ☐ Bleeding/bruising in the legs
- ☐ Wound that heals slowly

How long have you had these symptoms? ____

Have your symptoms gotten worse in recent months? Yes No When?_________________________

On your **WORST** day how severely do your symptoms impact your quality of life?
(None) 0 1 2 3 4 5 (Severe)

In what way do your symptoms negatively impact your activities/quality of life? ____________________________

____

Is it daily? Yes No Give example:____

Have you ever had blood clots in your legs? Yes No When? ________________________________
Which leg?___________________

Have you ever had vein stripping surgery? Yes No When? ________________________________
Which leg? __________________

Have you ever had vein ablation or injections? Yes No When? ________________________________
Which leg? __________________

Have you **ever taken** any medication for leg pain (eg, advil, etc.)? Yes No

If yes, what medication and how often? ____

Do you elevate your legs to relieve discomfort? Yes No

How often and how long have you tried elevating them?____

Have you EVER worn support /compression stockings? Yes No

If yes, what type and how long have you worn them? ____

Do they provide relief? Yes No

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Have you tried any other conservative therapy such as weight loss?

Yes No

Have you tried an exercise program as conservative therapy?

Yes No

If yes, please describe exercise tried and how long____

Have you ever injured either leg? Yes No

If yes, please describe ____

What is your occupation? ____

Do you stand much at work? Yes No

at home? Yes No

Does anyone else in your family have problems with leg veins? _____________________________________

Have you ever been diagnosed with any of the following conditions (check all that apply)?

- ☐ Phlebitis (inflammation or infection of the veins) When? _________________________
- ☐ Leg clots or deep venous thrombosis (DVT) When? _________________________
- ☐ Lung clots or pulmonary embolism (PE) When? _________________________
- ☐ Heart, liver, or kidney problems When? _________________________
- ☐ Cancer What type? __________________ When? _________________________
- ☐ Abnormalities of the blood, including bleeding or clotting abnormalities
- ☐ Lupus, scleroderma, or rheumatoid arthritis

Have you ever had any of the following experiences (check all that apply)?

- ☐ Leg swelling after a long airplane or car trip When? _________________________
- ☐ Leg trauma (including surgery) When? _________________________
- ☐ Pregnancy How many times? ________________

Have you ever used any of the following (check all that apply)?

- ☐ Tobacco When? _________________________
- ☐ Birth control pills When? _________________________
- ☐ Estrogen therapy When? _________________________
- ☐ Intravenous drugs When? _________________________

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PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU HAVE HAD IN THE PAST (OR HAVE NOW): ___________

____

____

____

____

PLEASE LIST ANY SURGERIES YOU HAVE HAD: ____

____

____

____

____

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY: ______________________

____

____

____

____

PLEASE LIST ANY MEDICATION ALLERGIES THAT YOU HAVE:

_________________________________ type of reaction: ____________________________

_________________________________ type of reaction: ____________________________

_________________________________ type of reaction: ____________________________

_________________________________ type of reaction: ____________________________

ARE YOU ALLERGIC TO:

LATEX? YES_____ NO______ type of reaction: ____________________________

ADHESIVE? YES______NO_____ type of reaction: ____________________________

ACRYLIC NAILS? YES_____NO_____ type of reaction: ____________________________

PLEASE LIST YOUR CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER AND HERBAL MEDICINES

Drug	Dosage	Date started

____

DO YOU TAKE ANY BLOOD THINNERS OR ASPIRIN? ____________________________________

HOW MANY PACKS OF CIGARETTES DO YOU SMOKE IN A DAY? ____________________________

HOW MANY ALCOHOLIC DRINKS DO YOU HAVE IN A TYPICAL WEEK? _________________________

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