Name: _____
Date: _____Date of Birth: _____ Age: ____

Patient History

Symptoms: ***(Please check if yes)***

Aching / pain in legs
Heaviness
Tiredness / fatigue
Itching / burning / warmth
Leg cramping
Leg restlessness
Throbbing
Swelling

Do your symptoms interfere with your sleep?
Are your symptoms worse later in the day?
Are your symptoms worse with or after activity?
Do your symptoms keep you from doing anything?

Check if you've had any of the following:

Heart disease
Peripheral arterial disease
HIV
Hepatitis
High blood pressure
Diabetes
Cancer
Leg trauma / surgery
Asthma/COPD
Major surgery / hospitalizations:
_____
_____
_____
Do you have an Advanced Directive? Yes

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

Was diagnosed with PAD in past
Have/had cramping leg pain that worsens with walking, forcing me to stop walking
Feet/toes become pale and painful with exercise or when elevating them
Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

Pain medications Weight loss Leg elevation Job change
Exercise Compression stockings or leg wraps? Strength of stockings: _____ mmHg

***Please list your* weight:** _____ lbs and **height:** ____ft ____in

Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling?
Do(es) your leg(s) feel better when moving it (them) or walking?
Are your leg symptoms worse when sitting or resting, without elevating your leg(s)?
Are your leg symptoms worse later in the day or night?

Please check below if you have, or have had, any of the following:

A prior evaluation for your veins: _____*(yr)*
Previous vein surgery or laser treatments: _____*(yr)*____*R*____*L*
Previous vein injections: _____*(yr)*____*R*____*L*
Bleeding from a vein: _____*(yr)*____*R*____*L*
A leg ulceration: _____*(yr)*____*R*____*L*
Superficial thrombophlebitis or an inflammation of a vein: _____*(yr)*____*R*____*L*_____ *(Location)*
Any type of blood clot: _____*(yr)*____*R*____*L*_____ *(Location)*
Any type of clotting disorder: _____ *(Diagnosis)*
Migraines with aura
Diagnosed with a PFO (patent foramen ovale)

A family history of vein disease
A family history of leg ulceration
A family history of blood clots
A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future?
Are you breast-feeding? Are your legs more painful associated with menstruation?
Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy?
Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's ages:_____

Provider reviewed with patient:_____ Date: _____

To save time on the day of your first appointment, you can print out each of the patient forms below, fill them out, and bring them with you.

*We are transitioning to an **Electronic Medical Record (EMR)** this year, and need the following information.*

Today's Date: _____ Your Appointment Time:_____ a.m. / p.m. Clinic Location: _____

Patient Name:	**Date of Birth:**

What is your "Reminder Preference" for communication for you? SELECT BEST ONE BELOW:

Home Phone:	May leave voice mail	Text	Cell Phone:	May leave voice mail	Text
Work Phone:	May leave voice mail	Text	Email:		

Preferred Primary Language
English Other:

Tobacco Use History Never smoked or used tobacco Quit on _____ (approx. date)
Current Tobacco User Amount: ____ cigarettes per day, or
Amount: ____ cigarettes per week
Amount: ____ other :_____
____ per day week; ____ per week

Allergies: or *No Known Allergies* **Your Allergic Response:**

_____	Rash	Nausea/Vomiting	Diarrhea	Shortness of Breath	Anaphylaxis	Other:_____
_____	Rash	Nausea/Vomiting	Diarrhea	Shortness of Breath	Anaphylaxis	Other:_____
_____	Rash	Nausea/Vomiting	Diarrhea	Shortness of Breath	Anaphylaxis	Other:_____

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

None

#	Medication Name	Dose	Frequency	Route
1				Oral
2				Oral
3				Oral
4				Oral
5				Oral
6				Oral
7				Oral
8				Oral

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Staff Signature: _____ Date: _____

Patient Education Handouts: *Tobacco Cessation <24 months*
Hypertension >140/90 or pre-hypertension 120/80 to 139/89

Physician Signature: _____ Date:_____

Diagnosis Code(s) from Encounter Form: (1) Primary:_____ Others:_____