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

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Patient History

Symptoms: *(Please check if yes)*	R	L
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: _____

veinclinics of America | Healthy looks good.

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 ☐ Work Phone: ☐May leave voice mail ☐Text ☐ Cell Phone: ☐May leave voice mail ☐Text ☐ Email:	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to State	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State
Preferred Primary Language ☐English ☐Other:		

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?

Date of Last Flu Shot ____/____ (Month/Year) ☐ No/Refused ☐Decline for Medical Reason → ☐ Allergy ☐ Other Medical Reason

Social History:

Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on _____(approx. date)
☐ Current Smoker → Started _____(approx. date) Amount of cigarettes: _____ per day
☐ Use tobacco in other forms → _____ Amount: _____per day

Alcohol Use History: Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES
If Yes: → How often? ☐ monthly or less ____ drinks per month ____ drinks per week ____ drinks per day
How often >6 drinks on one occasion in past year? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐Daily

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

_____ ☐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: _____

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Blood Pressure: _____ / _____ R L **MRN: _____**

Staff Signature: _____ Date: _____

Patient Education from Healthwise: ☐*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:_____