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:**______________

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Today's Date:_____________**Your Appointment Time:**________**a.m. / p.m. Clinic Location:**________________

Date of Birth:

Race	**Ethnicity**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State
Preferred Primary Language ☐English ☐Other: ☐ Decline to State	

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 ☐

Patient Signature:____ **Date:**____________________

O F F I C E U S E O N L Y

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:*______________________________