

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

<b>Symptoms:</b> (Please check if yes)	<b>R</b>	<b>L</b>	<b>Check if you've had any of the following:</b>		
Aching / pain in legs	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral arterial disease	<input type="checkbox"/>	
Tiredness / fatigue	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	
Itching / burning / warmth	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	
Leg cramping	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	
Leg restlessness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Leg trauma / surgery	<input type="checkbox"/>	
Do your symptoms interfere with your sleep?			<input type="checkbox"/>	Asthma/COPD	<input type="checkbox"/>
Are your symptoms worse later in the day?			<input type="checkbox"/>	Major surgery / hospitalizations:	<input type="checkbox"/>
Are your symptoms worse with or after activity?			<input type="checkbox"/>	_____	
Do your symptoms keep you from doing anything?			<input type="checkbox"/>	_____	
				Do you have an Advanced Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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)

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Exercise        | <input type="checkbox"/> Weight loss | <b>Have you worn compression stockings or leg wraps?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Leg elevation   | <input type="checkbox"/> Job change  | If yes, what was the strength of the stockings? _____ mmHg  |
| <input type="checkbox"/> Pain medication |                                      | If yes, how long did you wear compression stockings? _____ months _____ years                                     |

**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:**

- |  |  |
|--|--|
| <input type="checkbox"/> A prior evaluation for your veins: _____ (yr)   | <input type="checkbox"/> A family history of vein disease        |
| <input type="checkbox"/> Previous vein surgery or laser treatments: _____ (yr) ___R___L                                  | <input type="checkbox"/> A family history of leg ulceration      |
| <input type="checkbox"/> Previous vein injections: _____ (yr) ___R___L   | <input type="checkbox"/> A family history of blood clots         |
| <input type="checkbox"/> Bleeding from a vein: _____ (yr) ___R___L   | <input type="checkbox"/> A family history of a clotting disorder |
| <input type="checkbox"/> A leg ulceration: _____ (yr) ___R___L   |  |
| <input type="checkbox"/> Superficial thrombophlebitis or an inflammation of a vein: _____ (yr) ___R___L _____ (Location) |  |
| <input type="checkbox"/> Any type of blood clot: _____ (yr) ___R___L _____ (Location)                                    |  |
| <input type="checkbox"/> Any type of clotting disorder: _____ (Diagnosis)  |  |
| <input type="checkbox"/> Migraines with aura   |  |
| <input type="checkbox"/> Diagnosed with a PFO (patent foramen ovale)   |  |

**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:** \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to State
<b>Preferred Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to State	
<b>Weight:</b> _____ lbs. and <b>height:</b> _____ ft. _____ in	

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

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

**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

<input type="checkbox"/> None	#	Medication Name	Dose	Frequency	Route
	1				<input type="checkbox"/> Oral <input type="checkbox"/>
	2				<input type="checkbox"/> Oral <input type="checkbox"/>
	3				<input type="checkbox"/> Oral <input type="checkbox"/>
	4				<input type="checkbox"/> Oral <input type="checkbox"/>
	5				<input type="checkbox"/> Oral <input type="checkbox"/>
	6				<input type="checkbox"/> Oral <input type="checkbox"/>
	7				<input type="checkbox"/> Oral <input type="checkbox"/>

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

**OFFICE USE ONLY**

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

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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