

# Vein Therapy Center of Fairfield County

**Name:** \_\_\_\_\_ **MR#** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Height:**        \_\_\_ft \_\_\_in  
**Weight**        \_\_\_\_\_ lbs.

- I: Are you seeking treatment for**  
       \_\_\_Cosmetic reasons  
       \_\_\_Medical reasons  
       \_\_\_Both

**II: Describe your vein problems as specifically as you can:**

Please Rate symptoms 1-10, 10 being the most severe:

Symptoms (1-10)	Right Leg	Left Leg
Pain		
Achiness		
Restlessness		
Heaviness		
Burning		
Itching		
Night Cramps		
Swelling		
Bleeding		
Improved by:		
Worsened by:		

- Do you have a family history of varicose veins?
- Do you have a history of deep venous thrombosis or superficial vein thrombosis?
- Have you ever worn compression hose?

Do your symptoms affect you activities of daily life? If yes, how so?

<b>When did your veins first occur?</b>						
Age	-----			Is the pain exacerbated by		
Before pregnancy		Yes	No	Extended periods in one position		
During pregnancy		Yes	No	Heat	Yes	No
After trauma		Yes	No	Menstrual periods	Yes	No
After birth control		Yes	No	Exercising/Walking	Yes	No
Other				Medication	Yes	No
				Other (specify)	Yes	No
Are your veins getting larger?		Yes	No	Is the pain alleviated by:		
Have you ever been treated for varicose veins with:				Elevation of your leg	Yes	No
Surgical vein stripping		Yes	No	Elastic stockings	Yes	No
Laser or radiofrequency ablation		Yes	No	Exercising/Walking	Yes	No
Ambulatory phlebectomy		Yes	No	Does work require		
Sclerotherapy (Injection therapy)		Yes	No	Prolonged standing		
Topical Laser Therapy		Yes	No	Prolonged sitting		
Have you even been treated for				In the course of a day, how much time is standing: ____		
	Phlebitis	Yes	No			
	Leg ulcer	Yes	No			
	Pulmonary embolis	Yes	No			
	Deep venous throm	Yes	No			
	Hospitalized	Yes	No			

### III: What medical problems do you have

Do you have a history of

____Thyroid	Yes	No
____Heart disease	Yes	No
____Breathing problems/Asthma	Yes	No
____Diabetes	Yes	No
____Cholesterol	Yes	No
____Stroke	Yes	No
____Seizures	Yes	No
____Arthritis	Yes	No
____Hepatitis	Yes	No
____Easy bruising	Yes	No
____Poor healing	Yes	No
____Psychological Illness/Depression	Yes	No
____Kidney disease	Yes	No
____Weight Gain	Yes	No
____Hypertension (high blood pressure)	Yes	No
____Fainting (dizzy spells)	Yes	No
____Blood transfusions	Yes	No
____Hives	Yes	No
____Autoimmune disease (e.g. lupus)	Yes	No
____Bleeding disorders	Yes	No
____Dark spots on skin after injury, surgery	Yes	No
____HIV/AIDS	Yes	No

**IV: Allergies**

Do you have allergies to any medicines	Yes	No
Do you have allergies to foods	Yes	No
Do you have allergies to tape/adhesives	Yes	No
Do you have an allergy to iodine?	Yes	No
Do you have an allergy to latex?	Yes	No
Other _____	Yes	No

**V: What surgeries have you had?**

**VI: What medications do you take?**

Do you take any of the following?

____aspirin	Yes	No
____anticoagulants (blood thinners)	Yes	No
____pain killers	Yes	No
____arthritis medicines	Yes	No
____insulin, glucophage, glyburide, etc.	Yes	No
____oral contraceptives (birth control pills)	Yes	No
____estrogen, progesterone or other hormones	Yes	No
____steroids	Yes	No

**VII: Are you pregnant or planning pregnancy soon?** Yes No

**IX: Do you smoke?** Yes No

Packs per day \_\_\_\_ Years \_\_\_\_\_

Ex-smoker \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

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

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