



Diversified Vein
and Interventional Clinic

Varicose Vein Treatment

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

MEDICAL HISTORY

How did you hear about Diversified Vein Treatment? _____

What is the reason for this visit? _____

When did the problem start? _____

When do the symptoms occur? _____

How long do the symptoms last? _____

Do you experience any problems walking or exercising? _____

Are your symptoms worse at the end of the day or in the morning? _____

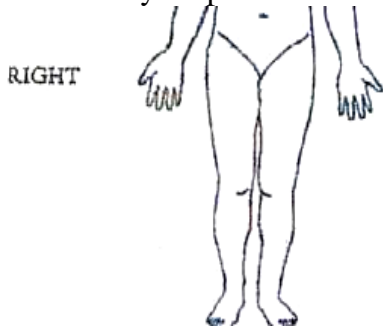
What relieves the symptoms? _____

Do your symptoms interfere with your lifestyle? _____

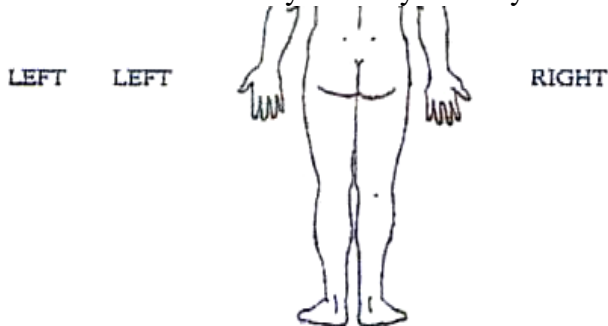
What are the symptoms?

Aching/Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Heaviness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Tiredness/Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Itching/Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Swollen Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Throbbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT
Restless Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RT <input type="checkbox"/> LT

Where is your pain now?



Mark the areas on your body where you feel your symptoms:



Have you had any diagnostic tests (labs, ultrasound, sclerotherapy) for your veins? _____

When was your last check up / physical exam? _____

Patient _____ Date _____

PLEASE LIST ANY PAST SURGERIES AND DATES:

_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST ANY OTHER MEDICAL ILLNESSES AND/OR HOSPITALIZATIONS:

_____	_____
_____	_____

LIST ALL MEDICATIONS/HERBAL SUPPLEMENTS/ALTERNATIVE AND TREATMENTS YOU ARE TAKING:

(Including over the counter, prescribed meds, steroids, inhalers, or drugs including aspirin)

MEDICATION	DOSE # PER DAY	/FREQUENCY	REASON FOR TAKING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? yes no

List ALL med allergies and type of reactions:

_____	_____
_____	_____
_____	_____

DO YOU HAVE A LATEX ALLERGY? YES NO DO YOU HAVE SEASONAL ALLERGIES? YES NO

DO YOU TAKE ANY BLOOD THINNERS: YES NO COUMADIN ASPIRIN dose _____

ADVIL / ANTI-INFLAMMATORY MEDS OTHER: _____

ALCOHOL USE: Do you drink? YES NO Never Occasional Daily # of Drinks per Week: _____

TOBACCO USE: Do you smoke? YES NO Packs Per Day: _____ For How Many Years? _____ Date Quit: _____

Do you Chew Tobacco? YES NO

RECREATIONAL DRUG USE: Do you use? YES NO

MARITAL STATUS: Single Married Separated Divorced Widowed

IS THERE ANY POSSIBILITY YOU COULD BE PREGNANT? Yes No N/A

Number of Children: _____

Occupation: _____ Retired? Yes No

Patient _____ Date _____

FAMILY HEALTH HISTORY:

Father: Age _____ Living Deceased Cause of Death or illness _____
Mother: Age _____ Living Deceased Cause of Death or illness _____
Brother(s): Age _____ Living Deceased Cause of Death or illness _____
Sister(s) Age _____ Living Deceased Cause of Death or illness _____
Children Age _____ Living Deceased Cause of Death or illness _____
Other _____

Please list family history of vein problems and how treated: _____

Review of Systems: *(Please circle any problems or symptom you have had or currently have)*

General: Recent illness, fever, chills, night sweats, weight loss/gain.
Skin: Bruising/bleeding disorders, rashes, itching, skin cancer, other disease of the skin _____.
Cardiovascular: Shortness of breath, palpitations, chest pain, swelling in extremities, murmur, angina.
Respiratory: Chronic cough, wheezing, pain with breathing, productive cough.
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, heartburn, ulcers, blood in stool, jaundice.
Genitourinary: Blood in urine, difficulty controlling bowel/bladder, urinary frequency/urgency or burning.
Neurological: Headaches, seizures, tremors, paralysis, loss of consciousness, dizziness.
Musculoskeletal: Joint pain, tingling, burning, backache, neck ache, fatigue.
Psychological: Anxiety, suicidal thoughts, mood swings, constant crying, loss of sleep.

*******Physician office to complete remainder of medical info*******

Prior Conservative treatment history: _____

Formal
Ultrasound _____

In Office Limited Venous Duplex Right Left Bilateral

Physical Exam

Height _____ Weight _____ V/S Temp _____ Respirations _____

B/P _____ Pulse _____ SAO2% _____

Measurements RLE _____

Visual Exam RLE _____

Measurements LLE _____

Visual Exam LLE _____

TESTS DATE FACILITY INTERPRETATION

CEAP Clinical Classifications:

- 0 - Asymptomatic. No visible or palpable signs of venous disease
- 1 - Spider veins, reticular veins, Telangiectasias
- 2 - Varicose veins
- 3 - Edema
- 4 - Skin changes
- 5 - Healed ulcer
- 6 - Active ulcer

Patient has Class: _____

Recommendation of the following procedure(s)

- | | |
|---|--|
| <input type="checkbox"/> Endovenous ablation- RFA of GSV [R] [L] | <input type="checkbox"/> Endovenous ablation- RFA of SSV [R] [L] |
| <input type="checkbox"/> Endovenous ablation- RFA perf or trib. [R] [L] | <input type="checkbox"/> Sclerotherapy [R] [L] |
| <input type="checkbox"/> Ultrasound Guided Sclerotherapy [R] [L] | <input type="checkbox"/> Stab Phlebectomy [R] [L] |
| <input type="checkbox"/> Other: _____ | |

Physician Comments: _____
