

Name: _____
 Date of Birth: _____ Age: _____
 Today's Date: _____
 How did you hear about us? _____

Referring Physician: _____
 Primary Care Physician: _____
 Specialist Physicians: _____
 Friends or Relatives who have seen Dr. Hayes: _____

PRIMARY REASONS FOR YOUR VISIT:

- | | | |
|---|--|---|
| <input type="checkbox"/> Leg Edema/Swelling | <input type="checkbox"/> Spider Veins | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Restless Legs | <input type="checkbox"/> Skin Discoloration / Thickening | <input type="checkbox"/> Leg Ulcers |
| <input type="checkbox"/> Leg Pain /Aching | <input type="checkbox"/> Cosmetic Appearance | <input type="checkbox"/> Other: _____ |

SIGNS / SYMPTOMS:

- Aching / Pain _____
- Tenderness _____
- Cramps _____
- Swollen Ankles _____
- Blood Clots _____
- Itching _____
- Tingling _____
- Heaviness _____
- Tiredness _____
- Phlebitis _____
- Redness _____
- Bleeding _____
- Skin Ulceration _____
- Varicose Veins _____
- Restless Legs _____

- | | |
|---|---|
| | Yes No |
|Unpleasant sensations with urges to move the legs | <input type="checkbox"/> <input type="checkbox"/> |
|Urges or Sensations worse with rest/relaxation | <input type="checkbox"/> <input type="checkbox"/> |
|Urges or Sensations improved with movement | <input type="checkbox"/> <input type="checkbox"/> |
|Urges or sensations worse in evenings or nighttime | <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | |

How many years have you had these symptoms? _____

How long have these symptoms affected your daily activities? _____

What conservative measures have you tried?

- Leg Elevation _____
- Avoid prolonged standing _____
- Weight Reduction _____
- Compression Stockings _____
- Walking / Exercise _____
- Baths / Hot Soaks _____
- Tylenol / Advil / Motrin / Ibuprofen / Aspirin /
Other Pain Meds / Analgesics _____
- Other Measures: _____

How have your veins been treated before?

- | | | |
|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Stripping | <input type="checkbox"/> Injections | <input type="checkbox"/> Phlebectomy |
| <input type="checkbox"/> Laser | <input type="checkbox"/> No Treatments | |

By Whom? _____ When? _____

ALLERGIES: None Yes

(If Yes, List the medication and reaction)

MEDICATIONS:

(List all Medications, Dosages, and Frequency)

CARDIAC Hx: YES/NO

Angina / Chest Pain

Arteriosclerosis

Cardiac Cath

Heart Angioplasty

Heart Attack

Heart Bypass

Heart Disease

Heart Failure

Heart Mitral Valve Prolapse

Heart Murmur

Heart Stent

High Blood Pressure

High Cholesterol

Other: _____

VASCULAR Hx: YES/NO

Aneurysm

Blood Clots / DVT

Free Bleeding

Phlebitis / Vein Infection

Pulmonary Embolus

Restless Legs

Stroke / TIA

Other: _____

MEDICAL Hx: YES/NO

Arthritis

Cancer

Diabetes Mellitus

Emphysema / Asthma

Fibromylgia

GERD / Hiatal Hernia

Hemorrhoids

Hepatitis A / B / C

HIV / AIDS

Kidney Disease

Liver Disease

Migraines/Headaches

Sleep Apnea

Stomach Ulcers

Other: _____

LEG Hx: YES/NO

Leg Infection

Leg Ulcers

Leg Trauma / Leg Injury

Lymphedema / Lymphangitis

Neuropathy

Other: _____

GYNECOLOGIC Hx: YES/NO

Pelvic Pain/Fullness

Pelvic Pain During Intercourse

Pelvic Pain w/ Menstrual Cycle

Pelvic Pain w/ Prolonged Study

Vulvar/Vaginal Varicosities

Other: _____

FAMILY Hx:

Restless Legs Heart Disease

Varicose Veins Free Bleeding

Spider Veins Cancer

Leg Ulcers Stroke

Blood Clots Sickle Cell

Other: _____

SURGICAL Hx: YES/NO

Back Operation

C-Section

Gallbladder Operation

Hemorrhoidectomy

Hysterectomy

Knee / Hip Operation

Neck Operation

Thyroidectomy

Tubal Ligation

Vascular Operation

Vein Operation

Other: _____

SOCIAL Hx:

Marital Status:

Single Married

Widowed Divorced

Children: _____

Next of Kin: _____

Family Here Today: _____

Cigarette Use: Never

Age when Started _____

PPD _____

Quit/When _____

Alcohol Use: Never

Age When Started _____

Drinks Per Week _____

Quit/When _____

Drug Use: Never

Type and Frequency _____

Quit/When _____

Occupation: _____

Retired Disabled

Does/Did Your Work Require:

Prolonged Sitting? Yes No

% of the Time Spent Sitting: 10% 25% 50% >50%

Prolonged Standing? Yes No

% of the Time Spent Standing: 10% 25% 50% >50%

REVIEW OF Sx's: YES/NO

Constitution

Fever/Chills

Night Sweats

Fatigue

Cardiovascular

Chest Pain/Pressure

Palpitations

Pacemaker

Musculoskeletal

Joint Stiffness

Joint Pain

Back/Neck Pain

Endocrine

Excessive Thirst/Urination

Hormone Problems

Thyroid Disease

Urinary

Kidney Stones

Blood in Urine

Painful Urination

Respiratory

Shortness of Breath

Wheezing/Asthma

Heavy Snoring

Neurological

Convulsions/Seizures

Numbness/Tingling

Vertigo

Hematologic

Anemia

Free Bleeding

Sickle Cell

Breast

Breast Lumps / Pain

Nipple Discharge

Last Mammogram: _____

Gastrointestinal

Irritable Bowel Syndrome

Yellow Jaundice

Constipation / Diarrhea

Gynecologic

Number of Pregnancies _____

Number of Live Births _____

Hormone Therapy

Are You Breast Feeding?

Are You Pregnant or Planning to be Soon?

PATIENT STATEMENT:

I certify that, to the best of my knowledge, the above information is accurate and complete.

Signed: _____