

Name: _____ Age: _____
 Date of Birth: _____ Today's Date: _____
 Friends or relatives who have seen us: _____
 How did you hear about us? _____

Please list all doctors (and phone #s) you see or have seen:

Doctor that consulted Dr. Hayes: _____
 Primary Care Physician: _____
 Specialist Physicians: _____

PRIMARY REASONS FOR YOUR VISIT:

- Leg Edema/Swelling Varicose Veins Restless Legs Skin Discoloration/Thickening
 Leg Ulcers Leg Pain /Aching Cosmetic Appearance Other: _____

SIGNS / SYMPTOMS:

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

How many years have you had these symptoms? _____

What activity makes it worse?

- Prolonged Standing Work
- Prolonged Sitting Walking
- Housekeeping Yard Work
- Travel Exercise

What conservative measures have you tried?

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

Have your veins been treated before? Y N

Stripping Injections Phlebectomy Laser

By Whom? _____ When? _____

ALLERGIES: None Yes
 (If Yes, List the medication and reaction)

MEDICATIONS: (List all Medications, Dosages, and Frequency. Include over-the-counter medications and supplements.)

Vaccinations: Flu Shot Y N Pneumonia or Pneumococcal Vaccine Y N

CARDIAC Hx: YES/NO

Cardiac Cath / When _____

Heart Stent / When _____

Heart Attack

Heart Bypass / When _____

Heart Disease

Heart Failure

Heart Mitral Valve Prolapse

Heart Murmur

High Blood Pressure

High Cholesterol

Angina / Chest Pain

Pacemaker

Cardiologist: _____

Other: _____

VASCULAR Hx: YES/NO

Aneurysm / Type _____

Blood Clots / DVT

Free Bleeding

Phlebitis / Vein Infection

Pulmonary Embolus

Restless Legs

Sickle Cell

Stroke / TIA

Warfarin Use

Coagulopathy: Type _____

Other: _____

MEDICAL Hx: YES/NO

Arthritis

Anemia

Cancer / Type _____

Diabetes Mellitus

Emphysema / Asthma / COPD

Fibromyalgia

Hepatitis A / B / C

HIV / AIDS

Kidney Disease

Liver Disease

Migraines / Headaches

Sleep Apnea

Stomach Ulcers

Current Wheelchair Use

Colonoscopy When _____

Mammogram When _____

Dexa Scan (bone scan) When _____

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 / Type _____

Leg Ulcers Stroke

Blood Clots

Other: _____

SURGICAL Hx: YES/NO

Back Operation

Hysterectomy

Leg / Knee / Hip Operation

Neck Operation

Pacemaker / ICD

Thyroidectomy

Vein Operation / When _____

Artery Operation

Heart Operation

Previous Anesthesia Problems

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 _____

Depression: Yes No

Occupation: _____

Retired

Disabled / Reason _____

REVIEW OF Sx's: YES/NO

What are you feeling currently?

Constitution

Fever / Chills

Night Sweats

Fatigue

Cardiovascular

Chest Pain

Chest Pressure

Palpitations

Musculoskeletal

Joint Stiffness

Joint Pain

Back / Neck Pain

Endocrine

Excessive Thirst / Urination

Hormone Problems

Thyroid Disease

Urinary

Kidney Stones

Blood in Urine

Painful Urination

Urine Incontinence

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

Gastrointestinal

Irritable Bowel Syndrome

Yellow Jaundice

Diarrhea

Gynecologic

Number of Pregnancies _____

Number of Live Births _____

Hormone Therapy

Type _____

Are You Breast Feeding?

Are You Pregnant or Planning to be Soon?

<p>PHYSICIAN STATEMENT:</p> <p><i>I have reviewed and summarized the above with the patient and present family.</i></p> <p>Kelsie Sarten: _____</p> <p>Dr Hayes: _____</p> <p>Date: _____</p>	<p>PATIENT STATEMENT:</p> <p><i>I certify that, to the best of my knowledge, the above information is accurate and complete.</i></p> <p>Signed: _____</p> <p>Date: _____</p>
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