THE VEIN AND LASER CENTER
OF NORTHERN COLORADO

OFFICE VISIT DATE: _____

Patient Medical History

Last Name: _____ First Name: _____ MI: _____ Nickname: _____

Sex: **M** or **F** Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Family Physician: _____ Referred By: _____

Reason for your visit today: _____ **Right** / **Left** / **Both**

How long have your symptoms been present? _____

SOCIOECONOMIC HISTORY

Occupation:_____ Marriage Status: **Married** or **Single**

Number of Children: _____ Spouse Name:_____

MEDICATION ALLERGIES

_____

MEDICAL HISTORY *Check all that apply to your own personal history*

- ☐ Anemia
- ☐ Anesthesia Problem
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Blood Transfusion
- ☐ CHF
- ☐ Clotting Disorder
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis (Blood Clots)
- ☐ Diabetes
- ☐ Embolism
- ☐ Emphysema
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Phlebitis
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Ulcers (legs)
- ☐ Venous Insufficiency
- ☐ Varicose Veins

SURGICAL HISTORY *Please include date of surgery*

_____

FAMILY HISTORY *For each family member, check all that apply.*

	Clotting Disorder	Diabetes	Heart Disease	High Blood Pressure	Stroke	Venous Thrombosis (Blood Clots)
Mother						
Father						
Sister						
Brother						
Daughter						
Son						

WOMEN ONLY

How many times have you been pregnant? _____

Have you ever had enlargement of varicose veins due to pregnancy? **Y** or **N**

Do you have varicose veins in the pelvic area? **Y** or **N**

Please continue to next page

SOCIAL HISTORY

Tobacco Use: **Y** or **N** Quit Date: _____ Packs/day: _____Years:_____

Smokeless Tobacco: **Y** or **N** Quit Date: _____ Marijuana Use: **Y** or **N**

Alcohol Use: **Y** or **N** Drinks/week: _____

MEDICATIONS *Please include both RX & OTC meds, supplements and vitamins with dosage*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

REVIEW OF SYSTEMS *Check all that apply to your own personal history*

RESPIRATORY	NEUROLOGICAL	CARDIAC	HEMATOLOGIC
☐ Chest Tightness	☐ Dizziness	☐ Chest Pain	☐ Bruises/Bleeds Easily
☐ Cough	☐ Headaches	☐ Palpitations	☐ Enlarged Lymph Nodes

VEIN SYMPTOMS

☐ Bleeding from Vein
☐ Blood Clots in Lung (Embolism)
☐ Calf Pain
☐ Deep Vein Thrombosis (DVT)
☐ Leg Aching/Pain
☐ Leg Cramps
☐ Leg Dermatitis
☐ Leg Heaviness/Fatigue
☐ Leg Itching/Burning
☐ Leg Pain Interfering with your Lifestyle
☐ Leg Swelling
☐ Leg Ulcer/Sore/Wound
☐ Phlebitis
☐ Restless Legs
☐ Skin Pigmentation

VEIN HISTORY

☐ Laser Treatment (EVLT)
☐ Radiofrequency Ablation (RF)
☐ Vein Injections
☐ Vein Ligation
☐ Vein Stripping
Other:_____

CONSERVATIVE MEASURES

Have you tried…?		When did you try this treatment?	How long did you try this treatment?	Did this treatment help?
Compression Stockings	Yes No		_____years _____months	Yes No
Leg Elevation	Yes No		_____years _____months	Yes No
Pain Meds (RX or OTC)	Yes No		_____years _____months	Yes No
Attempted Weight Loss	Yes No		_____years _____months	Yes No
Increase Physical Activity/Exercise	Yes No		_____years _____months	Yes No

Do your vein problems affect your…		How is this part of your life affected by your vein problems?
Daily Living	Yes No	
Job	Yes No	
Sleep	Yes No	
Physical Activity/Exercise	Yes No	

IN ORDER FOR INSURANCE TO PROCESS YOUR CLAIM YOU MUST COMPLETE THE ABOVE STATEMENTS