Smith Vein INSTITUTE

Hx-PE

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. Smith: _____

Primary Care Physician: _____

Specialist Physicians: _____

PRIMARY REASONS FOR YOUR VISIT:

- ☐ Dull pain/aching
- ☐ Tiredness/Heaviness
- ☐ Leg edema/Swelling
- ☐ Skin Discoloration/Thickening/Ulcer
- ☐ Restless legs
- ☐ Burning/Itching
- ☐ Cramps/Throbbing
- ☐ Other: _____

Vein History:

- ☐ Phlebitis (clot in leg)
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary embolism (lung clot)
- ☐ Bleeding from veins
- ☐ Hemorrhoids
- ☐ IV Drug Use
- ☐ HIV/Hepatitis
- ☐ Trauma/Leg injury
- ☐ Clotting Disorder
- ☐ Personal/Family history of recurrent miscarriages

What conservative measures have you tried?

- ☐ Leg Elevation
- ☐ Avoid prolonged standing
- ☐ Weight Reduction
- ☐ Compression Stockings (If yes, how long?) ☐ <6 wk ☐ 3mo ☐ 6wk ☐ >3mo
- ☐ Walking / Exercise
- ☐ Baths / Hot Soaks ☐ other
- ☐ Tylenol / Advil / Motrin / Ibuprofen / Aspirin / Other Pain Meds / Analgesics _____
- ☐ Other Measures: _____

How many years have you had these symptoms? _____

How long have these symptoms affected your daily activities? _____

How do they affect your daily activities?

- ☐ Cannot stand longer than a few hours without pain
- ☐ Increasingly more difficult to stand at work
- ☐ Can no longer perform routine functions at work/school
- ☐ Find it difficult to focus due to pain/symptoms
- ☐ Cannot walk without pain
- ☐ Find it more difficult to stand or walk
- ☐ Unable to gain access to work, community and/or leisure activities
- ☐ Other: _____

How have your veins been treated before?

- ☐ Stripping ☐ Injections ☐ Phlebectomy
- ☐ Laser ☐ No Treatments

By Whom? _____ When? _____

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

MEDICATIONS: *(List all Medications, Dosages, and Frequency)* (If yes, how long?)

over>

CARDIAC Hx: YES/NO

- Angina / Chest Pain
- Arteriosclerosis
- Cardiac Cath
- Heart Angioplasty
- Heart Attack
- Heart Bypass
- Atrial fibrillation
- 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
- Varicose Veins
- Spider Veins
- Leg Ulcers
- Blood Clots
- Heart Disease
- Free Bleeding
- Cancer
- Stroke
- 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

Occupation _____

- Requires prolonged standing?
- Involves prolonges sitting?

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 _____

Exercise: _____

Seldom Frequently

REVIEW OF Sx's: YES/NO

Constitution

- Fever/Chills
- Decreased appetite
- Fatigue

Cardiovascular

- Chest Pain/Pressure
- Palpitations
- Edema/ankle swelling

Musculoskeletal

- Muscle aches
- Joint Swelling
- Back/Neck Pain

Endocrine

- Excessive Thirst/Urination
- Excessive hunger
- Thyroid Disease

Urinary

- Kidney Stones
- Blood in Urine
- Painful Urination

Respiratory

- Cough
- Sleep apnea
- Wheezing/Asthma

Neurological

- Convulsions/Seizures
- Numbness/Tingling
- Migrane/headaches

Hematologic

- Easy bruising
- Clotting disorder
- Bleeding disorder

ENMT

- Sore throat
- Sinus drainage
- Decreased hearing

Gastrointestinal

- Painful swallowing
- Nausea / vomiting
- Constipation / Diarrhea

Gynecologic

- Irregular periods
- Breast problems
- Menopausal
- Are You Breast Feeding?
- Are You Pregnant or Planning to be Soon?

PHYSICIAN STATEMENT:

I have reviewed and summarized the above with the patient and present family.

Signed: _____

Date: _____

PATIENT STATEMENT:

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

Signed: _____

Date: _____