ADVANCED VEIN THERAPY
VARICOSE VEINS • SPIDER VEINS

927 W. Myrtle St. Boise, ID 83702 (208) 947-0100

New Patient Intake

Patient Name: _____ **Date**: _____

Primary Care Physician: _____ **Email address**: _____

How did you hear about AVT? (mark all that apply)

_____ Online
_____ Website
_____ On TV
_____ Previous Patient
_____ Other _____
_____ On the radio
_____ In print
_____ Providers office
_____ Family/Friend

Describe your main complaint (i.e., symptoms you are experiencing such as leg pain, swelling, itching, etc.):

_____

_____

_____

Please describe, in detail, when the symptoms began: _____

_____

_____

Is there anything that makes your symptoms worse? (i.e., standing for a prolonged period of time)?

_____

Is there anything that improves your symptoms (i.e., elevating your legs)? _____

_____

When you have prescriptions filled, which pharmacy do you use? _____

Please answer the following questions as completely as possible.

Have you had previous treatment for spider or varicose veins? . . . . . Yes No

- **If so, please list the year, procedure performed, and treating physician:** _____

_____

Have you had any ultrasound exams on your legs? . . . . . Yes No

If so, please list the year and which hospital/radiology facility completed the scan: _____

Do you have a history of skin ulcerations thought to be due to vein disease? . . . . . Yes No

Do you have a history of blood clots involving the superficial veins (aka SVT)? . . . . . Yes No

Do you have a history of blood clots involving the deep veins? (aka DVT)? . . . . . Yes No

Do you have a history of pulmonary embolism (also known as PE)? . . . . . Yes No

Have you ever been diagnosed with a blood clotting disorder? . . . . . Yes No

Have you ever had an episode of bleeding from a ruptured superficial varicose vein? . . . Yes No

- **If so, describe: _____**

Do you have a history of migraine headaches? with aura ____ without aura ____ . . . . . Yes No

- **If yes, how many migraines per month:_____**

Do you have a family history of varicose veins? . . . . . Yes No

- **If so, who in your family is affected?_____**

Do you currently take hormones or birth control pills? . . . . . Yes No

Does your occupation require you to sit or stand for long periods? . . . . . Yes No

- **If so, please describe (example: hairdresser for 20 years):**

Employer: _____ Occupation: _____

Do you exercise on a regular basis? If so, how many days per week? 1__ 2__ 3__ 4__ 5__ 6__ 7__

- **Please describe form of exercise :_____**

Do you or have you ever worn prescription graduated compression stockings? . . . . . Yes No

- **If so, how many months or years have you been wearing them? _____**
- **Who prescribed them?_____**

Do you elevate your legs to relieve the discomfort (i.e., use a reclining chair)? . . . . . Yes No

- **How many days per week? 1__ 2__ 3__ 4__ 5__ 6__ 7__**
- **For how many months/years? _____**

Do you ever take over-the-counter medication to relieve leg pain? . . . . . Yes No

- **Which medications have you tried (i.e ibuprofen, Tylenol)? _____**
- **How long have you taken?_____**

Have any of these treatments relieved your symptoms? . . . . . Yes No

Pregnancies?_____ Deliveries?_____ Did your symptoms increase during pregnancy? Yes No

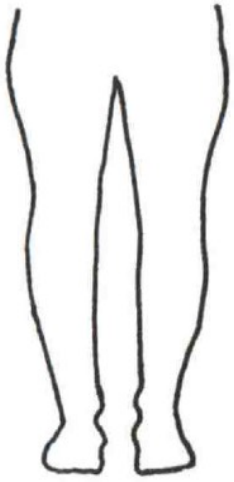
Please rate your pain severity on each leg below from 0-10 (10 being the worse)

	LEFT LEG		RIGHT LEG
Pain 0-10	_____	**Pain 0-10**	_____

Please mark an "X" by the symptoms you are experiencing

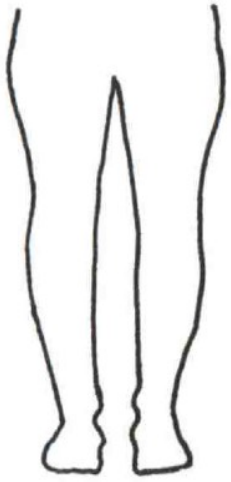
Aching	_____	**Aching**	_____
Throbbing	_____	**Throbbing**	_____
Stinging	_____	**Stinging**	_____
Burning	_____	**Burning**	_____
Swelling	_____	**Swelling**	_____
Cramping (Charlie horse)	_____	**Cramping (Charlie horse)**	_____
Leg feels tired	_____	**Leg feels tired**	_____
Leg feels heavy	_____	**Leg feels heavy**	_____
Ulcer (wound)	_____	**Ulcer (wound)**	_____
Skin discoloration	_____	**Skin discoloration**	_____
Itching	_____	**Itching**	_____
Numbness or tingling	_____	**Numbness or tingling**	_____
Restless leg	_____	**Restless leg**	_____

Anterior (front of legs)



Rt Lt

Posterior (back of legs)



Lt Rt

Activities of Daily Living

Does leg discomfort make it difficult to fall asleep at night? € yes € no Stay asleep at night? € yes € no
Do you ever have night-time leg cramps that wake you up? € yes € no
Do you ever need to elevate your legs as soon as you arrive home, thus delaying preparation of dinner? € yes € no
Do you find it is difficult to stand while cooking or washing dishes? € yes € no
Does leg fatigue or heaviness make it difficult to walk up stairs? € yes € no
Does your leg discomfort make it difficult to bathe, dress or groom yourself? € yes € no
Are there any chores at home that are now difficult to perform due to leg pain (vacuuming, yard work, etc.)? € yes € no

- Please describe: _____

Has leg discomfort made it more difficult (or kept you from performing) any of your daily occupational tasks? € yes € no

- Please describe: _____

Patient Medical History

Allergies and reaction:_____

Current Medications

Medication	Dosage (mg)	Frequency

Hospitalizations and/or Surgeries

Surgery / Reason for Hospitalization	Year

Adult Illnesses – do **you** have a personal history of any of the conditions listed below?

□ Cardiovascular Disease □ High Blood Pressure □ High Cholesterol □ Cancer

□ Tuberculosis □ Diabetes □ Thyroid Disease □ Arthritis

□ Asthma □ Other recurring disease: _____

Family History - do any of your family member have a history of any of the conditions listed below?

□ Cardiovascular Disease □ High Blood Pressure □ High Cholesterol □ Cancer

□ Tuberculosis □ Diabetes □ Thyroid Disease □ Arthritis

□ Asthma □ Other recurring disease: _____

Social History

Employer: _____ Retired? if yes, how many years? _____

□ Married _____ years □ Single □ Divorced

Smoke currently or ever? € yes € no if yes, how many years? _____ □ Alcohol use □ IV drug use

Review of Systems

Please check those that apply

General
- □ Appetite change
- □ Fatigue
- □ Fever
- □ Chills

describe:_____
_____

Skin
- □ Rashes
- □ Itching

describe:_____
_____

Eyes
- □ Blindness
- □ Decreased vision
- □ Blurred vision
- □ Double vision
- □ Eye pain

describe:_____
_____

Ear,Nose,Throat
- □ Dizziness
- □ Ringing in ears
- □ Decreased hearing
- □ Nose bleeds
- □ Hoarseness
- □ Dental problems
- □ Difficulty swallowing

describe:_____
_____

Cardiorespiratory
- □ Chest pain
- □ Palpitations
- □ Heart murmur
- □ Fainting
- □ Cough
- □ Bloody sputum
- □ Wheezing
- □ Difficulty breathing
- □ Sleep apnea

describe:_____
_____

Gastrointestinal
- □ Nausea
- □ Vomiting
- □ Blood in vomit
- □ Diarrhea
- □ Constipation
- □ Blood in stool
- □ Abdominal pain

describe:_____
_____

Genitourinary
- □ Urinary incontinence
- □ Burning with urination
- □ Blood in urine

describe:_____
_____

Musculoskeletal
- □ Joint pain
- □ Muscle pain
- □ Difficulty walking
- □ Leg cramping

describe:_____

Endocrine
- □ Temperature intolerance
- □ Weight change
- □ Menstrual change
- □ Skin change
- □ Hair change

describe:_____
_____

Neurologic
- □ Headaches
- □ Tremor
- □ Seizures
- □ Numbness/tingling

describe:_____
_____

Psychiatric
- □ Depression
- □ Anxiety

describe:_____
_____

_____

Hematologic

□ Clot in the deep veins
□ Blood clotting disorder
□ Transfusions
describe:_____

Allergic/Immune

□ Infection
□ Hives
□ Anaphylaxis
describe:_____
_____

By signing this I agree that the information supplied by me is accurate and complete to the best of my knowledge

Patient Signature:_____ Date: _____