ADVANCED VEIN THERAPY

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NEW PATIENT INTAKE

Patient Name: _____ Date: _____

Email Address: _____ Primary Care Physician: _____

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

_____ Online _____ Website _____ On TV _____ In print _____ On the radio

_____ Family/Friend _____ Provider's Office _____ Previous Patient _____ Other _____

Please 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

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

Do you experience migraine headaches? _____ Yes, approximately _____ # per month, _____ with aura, _____ without aura; _____ No

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

If so, please describe. Please include if you went to the ER for this, including date and location of ER visit. _____

_____

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

If so, who in your family is affected? _____

_____

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

If so, please describe (example: hairdresser for 20 years). Please include your occupation and employer.

_____

Do you exercise on a regular basis? _____ Yes _____ No

If so, please describe the form of exercise and frequency per week. _____

_____

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? For how many months/years? _____

_____

Do you ever take over-the-counter medication to relieve leg pain? _____Yes _____No

If so, which medications have you tried used, and how long have you taken them? _____

_____

Have any of these treatments relieved your symptoms? _____Yes _____No

Have you had pregnancies? _____ Deliveries? _____ Did your symptoms increase during pregnancy? _____Yes _____No

Please rate your pain severity on each leg from 0-10 (10 being the worse): Left leg (0-10) _____ Right leg (0-10) _____

Please check any of the following symptoms you are experiencing, specifying which leg is presenting the symptom.

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

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

If so, please describe. _____

_____

Has leg discomfort made it more difficult (or kept you from performing) any of your daily occupational tasks? ____Yes ____No

If so, please describe. _____

_____

Patient Medical History

Do you have any allergies? _____ Yes _____ No *If so, please describe and include reaction.*

_____

_____

_____

_____

_____

What medications are you currently taking? *Please include medication name, dosage, and frequency.*

_____

_____

_____

_____

_____

Hospitalizations, surgeries, and vaccinations. (Flu and Pneumococcal) *Include the type of surgery, and/or reason for hospitalization, and 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: _____

Adult Illnesses: Do any of your **family members** 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

Do you have an Advanced Directive? _____ Yes_____ No

Employer: _____ Retired? _____ Yes, for _____ years; _____ No

_____ Married, for _____ years; _____ Single; _____ Divorced

Do you smoke currently or have you ever? _____ Yes, for _____ years; _____ No

Do you use: Alcohol? _____ Yes _____ No; IV Drugs? _____ Yes _____ No

Review of Systems

Please check all that apply.

General

_____ Appetite change
_____ Fatigue
_____ Fever
_____ Chills

Describe _____

_____

_____

Skin

_____ Rashes
_____ Itching

Describe _____

_____

_____

Eyes

_____ Blindness
_____ Decreased vision
_____ Blurred vision
_____ Double vision
_____ Eye pain

Describe _____

_____

_____

Genitourinary

_____ Urinary incontinence
_____ Burning with urination
_____ Blood in urine

Describe _____

_____

_____

Ears, 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 _____

_____

_____

Allergic / Immune

_____ Infection
_____ Hives
_____ Anaphylaxis

Describe _____

_____

_____

Hematologic

_____ Clot in the deep veins
_____ Blood clotting disorder
_____ Transfusions

Describe _____

_____

_____

Endocrine

_____ Temperature intolerance
_____ Weight change
_____ Menstrual change
_____ Skin change
_____ Hair change

Describe _____

_____

_____

Neurologic

_____ Headaches
_____ Tremor
_____ Seizures
_____ Numbness/tingling

Describe _____

_____

_____

Psychiatric

_____ Depression
_____ Anxiety

Describe _____

_____

_____

Musculoskeletal

_____ Joint pain
_____ Muscle pain
_____ Difficulty walking
_____ Leg cramping

Describe _____

_____

_____

Gastrointestinal

_____ Nausea
_____ Vomiting
_____ Blood in vomit
_____ Diarrhea
_____ Constipation
_____ Blood in stool
_____ Abdominal pain

Describe _____

_____

_____

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

_____ _____

Signature Date