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 and/or surgeries

Please 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**

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*

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

Signature

Date