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)

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

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

Signature

Date