

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

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

Signature

Date