PHYSICIANS Vein Clinics

VEIN HEALTH & HISTORY FORM

Patient Name:_____ DOB: _____ / _____ / _____
Last First M.I.

Are you requesting evaluation at Physician's Vein Clinics for medical reasons? ____Yes ____No

What are your primary vein concerns?_____

Indicate whether you've ever experienced any of the following: (check all that apply) _____no vein symptoms

- ☐ burning/itching/tingling
- ☐ heaviness/fatigue
- ☐ pain/discomfort/cramping
- ☐ generalized leg swelling
- ☐ ankle swelling
- ☐ restlessness in your legs
- ☐ worsening leg veins
- ☐ bulging leg veins
- ☐ phlebitis (vein inflammation)
- ☐ leg ulcers or sores
- ☐ deep vein thrombosis
- ☐ trauma or surgery

Do you have a family history of vein disease? ____Yes ____ No

Any family history of blood clots? ____Yes ____No

Have you ever smoked tobacco? ____Yes ____No

Have you ever had a substance abuse problem? ____Yes ____ No

Are you currently working? Yes No What is your occupation:_____

Are you required to sit/stand for prolonged periods? ____Yes ____No

Do you walk during your job? ____Yes ____No

When did your vein problem first start?_____

Have you worn compression stockings before? ____Yes ____No If yes, then for how long? _____

What relieves your vein symptoms?_____ ____Don't know

What makes your vein symptoms worse?_____ ____Don't know

Have you been previously evaluated for a vein problem? Yes No Explain:_____

Indicate which prior vein treatments you have had: (check all that apply) _____ no prior vein treatments

- ☐ sclerotherapy injections
- ☐ surgical ligation
- ☐ surgical vein stripping
- ☐ ambulatory phlebectomy
- ☐ surface laser/light
- ☐ endovenous laser ablation
- ☐ radiofrequency closure
- ☐ other:_____

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List your current medications:_____

Do you have any medication allergies? Yes No Explain:_____

Do you have a latex allergy? Yes No Explain:_____

List prior surgeries:_____

List prior hospitalizations:_____

List medical conditions you are being treated for:_____

Indicate which of the following Medical Conditions you've ever had (check all that apply) _____None (Healthy)

☐ blood clotting disorder	☐ anemia or bleeding disorder	☐ heart defect or PFO
☐ migraine headaches	☐ high blood pressure	☐ diabetes
☐ asthma or lung disease	☐ pulmonary embolism	☐ deep vein thrombosis
☐ vein rupture (bleeding)	☐ stroke or CVA	☐ phlebitis or vein inflammation
☐ coronary artery disease	☐ peripheral artery disease	☐ renal or kidney disease
☐ hepatitis or liver disease	☐ joint replacement surgery	☐ cancer or malignancy
☐ HIV/AIDS	☐ hypercholestrolemia	☐ other:_____

For Women Only

Number of pregnancies:_____ Number of children:_____ Ages of children:_____

Number of miscarriages:_____ Are you pregnant or planning to get pregnant? Yes No

Do you have any pelvic or pubic area varicose veins? Yes No _____

Do you commonly experience pain with intercourse? Yes No _____

Patient Printed Name: _____ Date Signed: _____ / _____ / _____

Patient Signature: _____

_____ _____ _____ _____ RVT

Signature Date Physician Signature Date

Physicians Vein Clinics • 5009 South Louise Ave, Sioux Falls, SD 57108 • Phone: 605.274.0217 • Fax: 605.274.0217
Physicians Vein Clinics • 1119 4th Street, Suite 102, Sioux City, IA 51101 • 712.224.3662 • Fax: 605.275.6398
Physicians Vein Clinics • 2420 9th Ave SE, Watertown, SD 57201 • 605.878.2600 • Fax: 605.878.0407