



Patient Name _____ Occupation _____

Email Address _____

Date of Birth _____ Height _____ Weight _____

How did you hear about us? _____

Primary Care Physician _____

How long have you had this problem (please estimate)? _____

Have you ever had treatment for your veins in the past? Yes No

If yes, please explain: _____

Please check if you have even been diagnosed with or treated for the following:

- | | | |
|---|---|---|
| <input type="radio"/> Deep Vein Thrombosis | <input type="radio"/> Pulmonary Embolus | <input type="radio"/> Phlebitis/Blood Clots |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Heart Disease | <input type="radio"/> Hepatitis |
| <input type="radio"/> Diabetes | <input type="radio"/> Asthma | <input type="radio"/> Lung Disease/COPD |
| <input type="radio"/> Arthritis | <input type="radio"/> HIV/AIDS | <input type="radio"/> Bleeding disorder |
| <input type="radio"/> Peripheral Vascular disease | <input type="radio"/> Heart Valve Disease | <input type="radio"/> Stroke |
| <input type="radio"/> Other _____ | | |

Have you ever been tested for or been found positive for a Patent Foramen Ovale or Atrial Septal Defect?

Yes No

Do you suffer from migraines? Yes No

Please check if you have recently experienced any of the following:

- | | | |
|--|---|--|
| <input type="radio"/> Night Sweats | <input type="radio"/> Unexplained Weight Loss | <input type="radio"/> Persistent Cough |
| <input type="radio"/> Loss of Appetite | <input type="radio"/> Fever | <input type="radio"/> Hemoptysis (coughing up blood) |
| <input type="radio"/> Chest Pain | <input type="radio"/> Shortness of Breath | <input type="radio"/> Palpitations |

Have you had a flu shot in the past 12 months? Yes No



Have you ever had surgery? Yes No

If yes, what type of surgery and when? _____

Are you currently taking any medications? Yes No

If yes, please list all prescribed and over-the-counter, vitamins and herbals: _____

Are you allergic to any medications/foods? Yes No

If yes, please list: _____

Do you have a Latex allergy? Yes No

Do you take any blood-thinning medication (e.g. Coumadin, Plavix or Aspirin)? Yes No

If yes, please list: _____

Do you smoke? Yes Yes, but not anymore (stopped _____ yrs ago) No/Never

If yes, how many packs per day? _____

Do you consume alcohol? Yes No/Never

Is there a family history of blood clots? Yes No

If yes, please explain: _____

Females Only:

Have you had a mammogram in the past 2 years? Yes No

Are you pregnant or trying to become pregnant? Yes No

Are you currently breast-feeding? Yes No

Are you taking hormones or birth control pills (ex: Estrogen, Progesterone or Tamoxifen)? Yes No

If yes, please list _____

For how many years: _____



PATIENT MEDICAL HISTORY

Over 65 Years of Age:

Have you had a recent Pneumonia vaccine?

Yes

No

PHYSICIAN ONLY:

Left leg: GSV _____ SSV _____ AASV _____ Perforators _____

Right leg: GSV _____ SSV _____ AASV _____ Perforators _____

Blood Pressure: _____ / _____ Notes: _____