Appalachian Surgery & Vein / The Caudle Center

Vein History – Varicose Veins Chart#_____

Your appointment date & time is: _____/_____/_____@_____am pm. Please completely fully & return at least 2 days prior to appointment (Delay in appointment may result if not completed fully). Bring any medical records such as scans, labs, X-rays etc. It is necessary to bring your insurance card(s) and driver's license or other form of ID.

Patient Information **Bring Insurance Information & Photo ID to Office Visit**

Full Name:_____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Person to contact in case of emergency_____ Phone_____

Provide your email to access your health records online securely:_____

Referring Doctor(first & last name):_____ Group Practice Name: _____

Location: _____Phone#:____-____-_____Fax#:____-____-_____

DIRECTIONS Please answer the following questions. Circle Y for yes and N for no.

When did your 'bad veins' begin? _____How long have you been having trouble with 'bad' veins? _____ Started after pregnancies? Y N. Bad veins gotten worse recently? Y N_____. Gradually worse over time? Y N. Do you have mostly big bulging varicose veins? Y N. Mostly smaller spider veins? Y N. Both Y N. Which legs do you have trouble with: __Left __Right leg.

1. Ever had vein stripping surgery ☐ Yes ☐ No If yes, which leg and when? _____
2. Have you ever had vein injections? ☐ Yes ☐ No If yes, which leg and when? _____
3. Have you had a laser vein treatment? ☐ Yes ☐ No If yes, which leg and when? _____
4. Have you ever had a leg vein ulcer? ☐ Yes ☐ No If yes, which leg and when? _____
5. Have you ever had a blood clot? ☐ Yes ☐ No If yes, which leg and when? _____
6. Have you ever had phlebitis? ☐ Yes ☐ No If yes, which leg and when? _____
7. Have you had a pulmonary embolus? ☐ Yes ☐ No If yes, which leg and when? _____
8. Have you had a vena caval filter? ☐ Yes ☐ No If yes, which leg and when? _____
9. Do you experience any of the following in your legs?

Aching/pain?	☐ Right leg	☐ Left leg	☐ Both legs
Heaviness?	☐ Right leg	☐ Left leg	☐ Both legs
Tiredness/fatigue?	☐ Right leg	☐ Left leg	☐ Both legs
Itching/burning?	☐ Right leg	☐ Left leg	☐ Both legs
Swollen ankles?	☐ Right leg	☐ Left leg	☐ Both legs
Leg cramps?	☐ Right leg	☐ Left leg	☐ Both legs
Restless legs?	☐ Right leg	☐ Left leg	☐ Both legs
Throbbing?	☐ Right leg	☐ Left leg	☐ Both legs

Other?_____

10. Do you sometimes take aspirin, ibuprofen, NSAIDs, Tylenol, etc.) or any prescription medications for aching, cramping, burning, heavy, tired, or swollen legs? ☐ Yes ☐ No If yes, how often? _____
11. Are you taking any estrogen preparation? ☐ Yes ☐ No If yes, how often? _____
12. Any bleeding episodes from the 'bad veins'? ☐ Yes ☐ No If yes, how often? _____
13. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No, It doesn't help. If yes, how often? _____
14. Your daily activities /job require prolonged sitting or standing? ☐ Yes ☐ No If yes, which one & how many hours?___
15. What is your job or daily activities? _____
16. Do your vein symptoms interfere to some degree with your job or daily activities? ☐ Yes ☐ No If yes, how often? ___
17. Do you exercise? ☐ Yes ☐ No If yes, what kind of exercise and how often? _____
18. Do you wear prescription compression stockings? ☐ Yes ☐ No If yes, How long have you worn them? _____
19. Do you wear light support hose (i.e., Sheer Energy)? ☐ Yes ☐ No. If yes, do they provide relief? ☐ Yes ☐ No
20. Do you have to sit or take a break due to the discomfort-aching, swelling, cramping, burning, itching? ☐ Yes ☐ No
    If yes, how often during the day? _____

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21. Do you wear /use to wear high heeled shoes? ☐ Yes ☐ No If yes, how often? __Alot,__Occasionally,__Almost never.
22. Have you been overweight most of your adult life? ☐ Yes ☐ No ☐ NA
23. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No. If yes, when and what type of test (__venous duplex?) and by whom?_____. Did you have vein reflux? ☐ Yes☐ No

Family Vein History

7. Any family history of blood clots? ☐ Yes ☐ No If yes, who and cause of clot? _____
Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs from bad veins?
Father ☐ Brother(s) ☐ Grandmother /Grandfather / Both ☐ Mother ☐ Sister(s) ☐ Yes Aunt/Uncle /Other_____. Explain: _____

Past Surgical History (please check all that apply & date of surgery)

Heart Bypass/ Heart Angioplasty/Stents_____	Neck Surgery _____	Thyroid _____
Hernia_____ Location_____	Back Surgery _____	Colon _____
Gallbladder _____	Hip Surgery _____	Stomach/Gastric Bypass_____
Leg Bypass, R or L _____	Knee Surgery _____	Lung _____
Vein Surgery, R or L _____	Foot Surgery _____	Bladder _____
Carotid Surgery, R or L _____	Shoulder Tunnel _____	D & C _____
Aortic Aneurysm _____	Breast Surgery _____	Prostate _____
Tonsillectomy _____	Colonoscopy _____	Tubes Tied _____
Cataract/Eye _____	Gastroscopy _____	C-Section _____
Pacemaker _____	Carpal Tunnel _____	Hysterectomy _____
Abdominoplasty _____	Liposuction_____	Other _____

Past Medical History (please check for all that apply) (please circle **Active** for all that are currently active)

__Chest pain/angina	Active	__Motion sickness	Active	__Irregular Heart	Active
__High blood pressure	Active	__Kidney disease	Active	__Vision problems	Active
__Palpitations	Active	__Any Liver disease	Active	__Bladder Infections	Active
__Shortness of breath	Active	__Any Hepatitis	Active	__Cancer	Active
__Heart attack	Active	__Thyroid disease	Active	__Depression	Active
__Asthma	Active	__Diabetes	Active	__Stroke/TIA	Active
__HIV	Active	__Anemia	Active	__Blood Disorder	Active
__Bronchitis	Active	__Arthritis	Active	__Seizures	Active
__Tuberculosis	Active	__Dentures	Active	__Anorexia	Active
__Hernia	Active	__TMJ syndrome	Active	__Scarring/Keloids	Active
__Ulcers	Active	__Fibromyalgia	Active	__Pacemaker	Active
__Nausea/Vomiting	Active	__Insomnia	Active	__Sinus problems	Active
__Malignant Hyperthermia	Active	__Sleep Apnea	Active	__Pancreatitis	Active
__Recreational Drugs	Active	__Oxygen use	Active	__Cold Sores	Active
__Neuropathy	Active	__Varicose vein	Active	__Abnormal Healing	Active
__(PCOS) Polycystic Ovarian disease		Active		__Gout	Active

Other _____
_____

Review of Systems: (Please circle all that apply)

- **Constitutional:** Fever, chills, night sweats, trouble swallowing, weight loss/gain _____lbs.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **Eyes:** Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration.
- **ENT:** Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems
- **Cardiac:** Chest Pain, Angina, Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test _____, Echocardiogram _____
- **Respiratory:** Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.
- **GI:** Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool everyday _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps, generally eat high or low fiber diet, high or low fat diet.

- **GU:** Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes.
- **GYN: # of Pregnancies _____, # of Births _____, # of miscarriages/abortions _____,**
- **Last menstrual period _____,** Painful, Painful intercourse. Menses: irregular, light, heavy.
- Approximate age at menopause _____.
- **Musculoskeletal:** Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.
- **Neurologic:** Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.
- **Psych:** Depression, Anxiety, Psychosis, rehab for drug or alcohol abuse, Dementia, Bipolar
- **Endocrine:** Excessive thirst or urination, Thyroid disease
- **Heme/Immune:** HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder.

Medications: List all medications, dosages, frequency, and include all natural supplements: _____

_____

_____

Any History of 'Panic' or 'Anxiety' attacks? Yes No Last attack? _____
Any history of Staph or MRSA infections? Yes No Last episode? _____
Any bleeding problems? Yes No Explain: _____
Any recent use of Diet Pills (eg phentermine): Yes No
Latex Allergy: Yes No Xylocaine "caine" any local anesthetic Allergy: Yes No
Drug Allergies: _____
Environmental Allergies: _____
Social History: Check all that apply: Alcohol ____. How much & how often _____
Tobacco Smoke _____ Dip _____ Chew ____ How much & how long? _____
If you quit, when? _____ **E-Cigs**: How much and how long? _____
Marijuana Use: Yes No
History of Substance / Drug Abuse or Alcohol Abuse? No Yes Explain: _____
Live Alone _____ Employed _____ Disabled _____ Retired _____ Student _____ Homemaker _____ Married ____
Divorced ____ Widowed ____ Never Married _____
Family History: Please specify which family member (s): □ Cancer □ Bleeding Disorder □ Diabetes □ Hypertensions
□ Heart Problems □ Aneurysm □ Stroke □ Varicose Veins Explain: _____

_____

Other Information by Patient _____

_____

_____

_____

ACP: Pelvic venous reflux &/or Iliac vein occlusion / stenosis: Generally treat leg VV first & if subsequent problem, then investigate. Most people don't have PVR or IVO. Stent treatments have an increasing restenosis rate.

Patient signature: _____ Date: ___/___/_____

Physician / NP / PA: _____ Date: ___/___/_____

Surgeon: _____ Date: ___/___/_____