Appalachian Surgery & Vein / The Caudle Center

Venous Health History – Spider Veins Chart#_____

Please complete fully & bring with you to your appointment (Delay in appointment may result if not completed fully).

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:_____-_____-_____
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:_____

How did you hear about us?

☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Radio ☐ Billboard ☐ TV
☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Different Website _____

Reason for visit including areas of concern: Please list when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? _____

_____

_____

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.

☐ 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? _____
21. Do you wear /use to wear high heeled shoes? ☐ Yes ☐ No If yes, how often? __A lot,__Occasionally,__Almost never.

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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 venous reflux? ☐ Yes ☐ No

Past Surgical History (please list all surgeries with approximate date): _____

_____

Past Medical History (please list all medical problems): _____

_____

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

_____

_____

Check if Allergy: ☐ Latex: ☐ Xylocaine, any local anesthetic: ☐ Sclerotherapy agent: example polidocanol
Drug Allergies: _____
Environmental Allergies: _____
Social History: Check all that apply: Alcohol ____. **Tobacco** Smoke ___ Dip ___ Chew ___ If you quit, when? _____ **___ E-Cigs**. **___ Marijuana Use ___ History of Substance / Drug Abuse or Alcohol Abuse?**
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 □ Blood clots Explain: _____

_____

Patient Signature: _____ Date: _____/_____/_____

VEIN DISEASE PHYSICAL EXAM:

Weight (lbs) _____ Height (in) _____ BMI _____ BP _____/_____ P _____ R _____ T _____
GENERAL: Ambulation __normal. __Healthy in NAD.
HEENT: _normocephalic, _PERRL, _conjunctiva non-icteric, _oral pharynx w/o lesions, _neck supple w/o masses. Teeth_____. Other: _____
CHEST: _good _fair _ poor BS bilateral, _No wheezes, rales, rhonchi. _rhonchi, __wheezes, _Chest wall nl, __No labored breathing
HEART: _RRR, _IRR, _no significant murmurs, Grade __/6 murmur, _no clicks or rubs. _____
ABDOMEN: _soft, _flat, _mild moderately _ very rotund/obese, _non-tender, _no masses, _no hernias

_____

EXTREMITIES: Good ROM__UE,__LE, _No peripheral cyanosis, clubbing, or edema, _____. Other _____

_____

SKIN: _Warm & dry. _No skin lesions or rashes, _normal skin pigmentation, _____
Except:_____
NEURO: _gross motor & sensory intact, _mentation normal, _speech & reflexes grossly normal
PULSES: _bilateral 2+ at _radial, _ulnar, _femoral, _DP, _PT, __Cap Refill normal. Except _____
SPINE: _no scoliosis, _no kyphosis, _spinal curvature is normal, _no tenderness _____
VEIN: ___ Varicose veins -R L Bi. ___ spiders/ telangiectasia -R L Bi. ___fibrosis/pigmentation, -R L Bi. ___venous ulcer-R L Bi Nl. Reticular veins –R L Bi. _____

_____

{25% of patients presenting with only spider veins have great or short saphenous insufficiency}

ASSESSMENT: ☐ Spider veins ☐ Reticular veins ☐ Varicose veins ☐ Other: _____

PLAN: ☐ Sclerotherapy ☐ Venous Duplex ☐ Gradient support stockings ☐ Other: _____

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