MINNEAPOLIS RADIOLOGY
Experts in medical imaging

MINNEAPOLIS VASCULAR PHYSICIANS
Experts in vascular care

VEIN HEALTH HISTORY FORM

Patient Name: _____ **Date of Visit:** _____
Date of Birth: _____ **Age:** _____ **MRN: (office use only)** _____

How did you hear about the Minneapolis Vein Center? _____
What is your most significant symptom?_____

Who is your regular primary physician? _____
What other physicians do you see?_____
May we send a letter to your physician(s)? Circle the physician(s) to whom we may send a letter.

Vein History

Which leg is affected? Right Left Both
Which leg is worse? Right Left Both
How are your daily activites affected by your legs?_____
_____
How long have your legs bothered you? # Years:_____ #Months:_____
What activites make your leg(s) feel worse? _____
_____

Circle Rt (right) or Lt (left) or both if you CURRENTLY experience any of the following leg symptoms.

Aching/pain in your legs	Rt Lt	Heaviness	Rt Lt
Tiredness/fatigue	Rt Lt	Itching/burning	Rt Lt
Swollen Ankles	Rt Lt	Leg cramps	Rt Lt
Restless Legs	Rt Lt	Throbbing	Rt Lt
Leg wound(s)	Rt Lt	Groin varicose veins	Rt Lt

Other: _____

For women only

Do you have deep pelvic pain? Yes No
Do you have pain with intercourse? Yes No
Are your symptoms in either your pelvis or legs worse with your menstrual period? Yes No

What can you do to improve your leg symptoms? (Circle all that apply.)

Elevate Walk Ice Massage Stockings Ace wraps Pain medication
If you circled elevation: How often? _____ For how long each time? _____Since when?_____
If you circled Ace wraps:
For how long have you used wraps? _____ How often? _____ Does it help? Yes No
If you circled pain medication, circle which one(s): Aspirin Ibuprofen Aleve Tylenol Other:_____
For how long have you used it? _____ How often? _____ Does it help? Yes No

Do you have any concerns about the appearance of you leg(s)? Yes No
If yes, please describe:_____
If yes, would you like to hear about cosmetic treatments, if appropriate? Yes No

Patient Name: _____ **Patient History Page 2**

Prior Vein Evaluation and Treatment

Have you ever had your veins evaluated by a doctor before? Yes No
If yes, what doctor and when? _____
Did the doctor perform any tests (for example, an ultrasound)? Yes No

If you have had any of the following leg vein treatments, circle which leg and fill in when.
Stripping: Rt Lt_____ Venous ablation: Rt Lt_____ Phlebectomy: Rt Lt_____ Injections: Rt Lt_____

Circle if you have previously had: Deep Vein Clot (DVT) Superficial Blood Clot (Phlebitis) Leg Wound
Please describe:_____

Compression Stocking Use

Have you ever worn compression stockings in the past? Yes No
If yes, when? _____ If yes, for what length of time? Years:___ Months:___
Do you currently wear prescription compression stockings? Yes No
If yes, do they help? Yes No
If no, why not? _____
Do you currently wear light support hose (example sheer energy)? Yes No
If yes, do they help? Yes No

PAST MEDICAL HISTORY

Are you presently under the care of a physician for any illness? Yes No
If yes, please explain: _____
Have you ever had surgery of any kind? Yes No
If yes, please specify: _____
_____
Have you ever been hospitalized for anything other than surgery? Yes No
If yes, please specify: _____
_____
Have you ever been told that you should not take Ibuprofen? Yes No
If yes, why?_____
Do you have any of the following? If yes, please specify.

Heart Disease	Yes No _____		Pacemaker	Yes No_____	
Lung Disease	Yes No _____		Anemia	Yes No_____	
Hepatitis	Yes No _____		Arthritis	Yes No_____	
High cholesterol	Yes No _____		Diabetes	Yes No_____	
Asthma	Yes No _____		Thyroid	Yes No_____	
High Blood Pressure	Yes No _____		Migraine	Yes No_____	

Other significant medical history not listed above: _____
_____

For women only

Currently pregnant?	Yes	No
How many times have you been pregnant?	_____	
How many live childbirths?	_____	
Currently breastfeeding?	Yes	No
Planning on becoming pregnant?	Yes	No

Patient Name: _____ **Page 3 Patient History**

Please list all current medications (prescription & over the counter) you are taking.

Medication	Dosage	Frequency

Do you have any allergies?	Describe how they affect you:
_____	_____
_____	_____

Are you allergic to shrimp/shellfish/iodine, IVP dye and/or IV contrast dye? If yes, please circle.
If yes, what type of reaction did you have?_____

_____

Family History

It is important for us to know your family medical history. Please include if any family member has experienced any of the following. Circle all that apply.

Mother: Alive/Deceased Age:____ Varicose Veins Blood clots Heart Disease Congestive Heart Failure Fibroids Other

Father: Alive/Deceased Age:____ Varicose Veins Heart Disease Blood clots Congestive Heart Failure Other

Brothers: # _____ Ages:_____ Varicose Veins Heart Disease Blood clots Congestive Heart Failure Other

Sisters: # _____ Ages:_____ Varicose Veins Blood clots Heart Disease Congestive Heart Failure Fibroids Other

Children: # _____ Ages:_____ Varicose Veins Blood clots Heart Disease Congestive Heart Failure Fibroids Other

Social History

What is your profession? _____
Do you smoke? _____ If yes, how much? _____
Do you drink alcohol? ____ If yes, how much? _____
Does anyone live at home with you? Who? _____