



MINNEAPOLIS VEIN CENTER
Experts in Vein Care

Patient Name: _____ **Date of Visit:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

How did you hear about the Minneapolis Vein Center? _____

Who is your regular primary physician? _____

What other physicians do you see? _____

What is your most significant symptom? _____

Vein History

Which leg is affected? Right Left

Which leg is worse? Right Left

How are your daily activities affected by your legs? _____

How long have your legs bothered you? Years: _____ Months: _____

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 have you tried 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 pain medication, circle which one(s): Aspirin Ibuprofen Aleve Tylenol Other: _____

For how long have you used it? _____ How often? _____ Does it help? _____

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

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 _____ **Sclerotherapy:** 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, for what length of time? Years: _____ Months: _____

Do you currently wear compression stockings? Yes No

How long have you been currently wearing compression stockings _____

Name of physician who prescribed your stockings: _____

PAST MEDICAL HISTORY

Are you presently under the care of a physician for any illness? Yes No

If yes, please explain: _____

Please list previous surgeries: _____

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?

Congestive Heart Failure	Yes	No	Cancer	Yes	No
Back Pain	Yes	No	Heart Disease	Yes	No
Lung Disease	Yes	No	Pacemaker	Yes	No
Clotting Disorder	Yes	No	Hepatitis	Yes	No
Arthritis	Yes	No	Diabetes	Yes	No
High Cholesterol	Yes	No	Asthma	Yes	No
Thyroid	Yes	No	Migraine	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No

If you circled **YES** to any of the above, please describe: _____

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

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

Medication	Dosage	Frequency

Do you have medication allergies?	Reaction:
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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 foll
 Circle all the apply.

Varicose Veins:	Mother	Father	Brothers	Sisters	Children
Heart Disease:	Mother	Father	Brothers	Sisters	Children
Blood Clots:	Mother	Father	Brothers	Sisters	Children
Diabetes:	Mother	Father	Brothers	Sisters	Children
Fibroids:	Mother	Father	Brothers	Sisters	Children
High Blood Pressure:	Mother	Father	Brothers	Sisters	Children
Congestive Heart Failure:	Mother	Father	Brothers	Sisters	Children
Cancer:	Mother: Type _____	Father: Type _____	Brothers: Type _____	Sisters: Type _____ Children: Type _____	

Social History

What is your profession? _____
 Do you smoke? _____ Did you ever? _____ When did you quit? _____
 Do you drink alcohol? _____ If yes, how much? _____
 Does anyone live at home with you? _____ Who? _____