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
Leg symptoms interfering with: (circle)
walking work exercise stairs kneeling sleeping driving prolonged standing social activities other_____
_____
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

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 a history 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

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

What pharmacy do you use? _____

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

Medication	Dosage	Frequency

Medication Allergies	Reaction:

Allergy to Iodine or IV contrast dye? Reaction:_____

Allergy to adhesives, skin glue, bandages, artificial nails or eyelashes? (please circle)

Reaction:_____

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 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? _____

Does anyone live at home with you? _____ Who? _____