Maryland Vein Professionals LLC

New Patient History Form Please fill form completely.

Name
Date
How Heard
Primary Doc

I) Vein Health History

Current Age _____
Veins Problematic for _____ years

First Symptoms

☐Varicose Veins	☐Both	☐R	☐L
☐Pain	☐Both	☐R	☐L
☐Swelling	☐Both	☐R	☐L
☐Other _____			

Current Symptoms

☐Aching	☐Both	☐R	☐L
☐Swelling	☐Both	☐R	☐L
☐Fatigue	☐Both	☐R	☐L
☐Itching	☐Both	☐R	☐L
☐Burning	☐Both	☐R	☐L
☐Throbbing	☐Both	☐R	☐L
☐Tingling	☐Both	☐R	☐L
☐Ulcers	☐Both	☐R	☐L
☐Restless Legs	☐Both	☐R	☐L
☐Bleeding	☐Both	☐R	☐L
☐Phlebitis	☐Both	☐R	☐L
☐Dermatitis	☐Both	☐R	☐L
☐Skin Color Change	☐Both	☐R	☐L
☐**Other** _____			

How Symptoms Interfere with Life:

☐Work	☐Air Travel
☐Leisure Activity	☐Long Car Travel
☐Routine Activity	☐Child Care

IMPORTANT: Give example(s) of above

(You are required to document how symptoms interfere with living to obtain pre-authorization)

_____
_____
_____

Pregnancy History
☐No Pregnancies ☐How many? ___
☐First Noticed Veins ☐Veins worsened

Blood Clots

☐DVT	☐Both	☐R	☐L
☐Phlebitis	☐Both	☐R	☐L

Occupation_____
Prolonged ☐Sitting ☐Standing ☐Both

Prior VeinTreatments				**Date**
☐Sclerotherapy	☐Both	☐R	☐L	_____
☐Laser	☐Both	☐R	☐L	_____
☐Stripping	☐Both	☐R	☐L	_____
☐Phlebectomy	☐Both	☐R	☐L	_____
☐Closure	☐Both	☐R	☐L	_____
☐Other _____				

II) Conservative Measures Attempted to Control Symptoms

Compression Stocking Use

(You are required to document your current and past stocking use for treatment pre-authorization)

☐ First used_____ years ago
☐ Use Currently
Strength ☐ 15-20 ☐20-30 ☐ 30-40
☐Used with _____
(i.e. Sclero, Pregnancy, Surgery, Work)
☐ Who Suggested _____
Period of past use _____ ☐months ☐ yrs
Initials _____

Do You Have Symptom Relief with :
Elevation ☐Yes ☐No ☐Partial
Anti-Inflam. Med ☐Yes ☐No ☐Partial
I have attempted weight reduction :
☐Yes ☐No ☐Not an issue
I exercise:
☐Daily ☐_____ Times per week
☐Weekly ☐No regular exercise

II) General Medical History

Medications □None

_____
_____
_____
_____
_____
_____

Medication Allergies
□None □Yes
If Yes, to what? Type of Reaction
_____ _____

Prior reaction to Lidocaine, Novacaine, Iodine, or Latex?
□None □Yes
If Yes, to what? Type of Reaction
_____ _____

Past or Current Medical Conditions
□No other problems

_____
_____
_____
_____
_____

Surgeries/Dates □None

_____
_____

Family with Varicose Veins
□Mother □Father
□Others_____
□Treatments?_____

Social History
Marital Status □S □M □D □W
Smoking □Never □Quit __ Yrs ago
□Yes___Pks/d
Alcohol □Never □Social □Moderate

Review of Systems *(circle if yes)*
Head & Neck □No Complaints
Migraines Glasses Sinusitis Dental
Respiratory □No Complaints
Asthma Emphysema Bronchitis
Cardiac □No Complaints
Angina Murmur High BP
Gastrointestinal □No Complaints
Ulcer Reflux IBD Diverticulosis
Genitourinary □No Complaints
UTIs Frequency
Extremities □No other Complaints
Arthritis _____
Neuropsych □No Complaints
Anxiety Depression Neuropathy
Endocrine □No Complaints
Diabetes Thyroid _____
Hematological □No Complaints
Lupus Clotting Disorder _____

PLEASE SIGN BELOW:

I affirm the above is true to the best of my knowledge _____