Name: ____
Date: ____________Date of Birth: __________ Age: ____

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AESTHETICS • VEIN • LASER

Patient History

Symptoms: ***(Please check if yes)***

	R	L
Aching / pain in legs	☐	☐
Heaviness	☐	☐
Tiredness / fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your symptoms worse with or after activity? ☐
Do your symptoms keep you from doing anything? ☐

Check if you've had any of the following:

Heart disease ☐
Peripheral arterial disease ☐
HIV ☐
Hepatitis ☐
High blood pressure ☐
Diabetes ☐
Cancer ☐
Leg trauma / surgery ☐
Asthma/COPD ☐
Major surgery / hospitalizations: ☐
____
____
____

Do you have an Advanced Directive? ☐Yes

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

☐ Was diagnosed with PAD in past
☐ Have/had cramping leg pain that worsens with walking, forcing me to stop walking
☐ Feet/toes become pale and painful with exercise or when elevating them
☐ Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

☐ Pain medications ☐ Weight loss ☐ Leg elevation ☐ Job change
☐ Exercise ☐ Compression stockings or leg wraps? Strength of stockings: __________ mmHg

***Please list your* weight:** __________ lbs and **height:** ____ft ____in

Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling? ☐
Do(es) your leg(s) feel better when moving it (them) or walking? ☐
Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? ☐
Are your leg symptoms worse later in the day or night? ☐

Please check below if you have, or have had, any of the following:

☐ A prior evaluation for your veins: _______________*(yr)*
☐ Previous vein surgery or laser treatments: __________*(yr)*____*R*____*L*
☐ Previous vein injections: __________*(yr)*____*R*____*L*
☐ Bleeding from a vein: __________*(yr)*____*R*____*L*
☐ A leg ulceration: __________*(yr)*____*R*____*L*
☐ Superficial thrombophlebitis or an inflammation of a vein: __________*(yr)*____*R*____*L*__________________ *(Location)*
☐ Any type of blood clot: __________*(yr)*____*R*____*L*____ *(Location)*
☐ Any type of clotting disorder: ____ *(Diagnosis)*
☐ Migraines with aura
☐ Diagnosed with a PFO (patent foramen ovale)

☐ A family history of vein disease
☐ A family history of leg ulceration
☐ A family history of blood clots
☐ A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? ☐
Are you breast-feeding? ☐ Are your legs more painful associated with menstruation? ☐
Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? ☐
Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's ages:______________________

Provider reviewed with patient:____ **Date:** _____________

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_____Your Appointment Time: _______ a.m. / p.m. Clinic Location: ________________

Patient Name:		Date of Birth:
What is your "Reminder Preference" for communication for you? SELECT BEST ONE BELOW: ☐ Home Phone: ☐May leave voice mail ☐Text ☐ Work Phone: ☐May leave voice mail ☐Text ☐ Cell Phone: ☐May leave voice mail ☐Text ☐ Email:		☐
Preferred Primary Language ☐English ☐Other:	☐ ☐	

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?
Date of Last Flu Shot ____/____ (Month/Year) ☐ No/Refused ☐Decline for Medical Reason → ☐ Allergy ☐ Other Medical Reason

Social History:
Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on _______________(approx. date)
☐ Current Smoker → Started ____________(approx. date) Amount of cigarettes: _____ per day
☐ Use tobacco in other forms → _____________________ Amount: _________per day

Allergies and Your Allergic Response: or ☐ *No Known Allergies*

_____________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:___________
_____________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:___________
_____________________ ☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:___________

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

☐ *None*

#	Medication Name	Dose	Frequency	Route
1				☐Oral ☐
2				☐Oral ☐
3				☐Oral ☐
4				☐Oral ☐
5				☐Oral ☐
6				☐Oral ☐
7				☐Oral ☐
8				☐Oral ☐

Patient Signature: ____ **Date:** ______________________

O F F I C E   U S E   O N L Y

Blood Pressure: ________ / ________ **R L** **MRN:** ________________________

Staff Signature: ____ **Date:** ________________________

Patient Education from Healthwise: ☐*Tobacco Cessation <24 months* ☐*Hypertension >140/90* or *pre-hypertension 120/80 to 139/89*

Physician Signature: ____ **Date:**________________________

Diagnosis Code(s) from Encounter Form: (1) Primary: _______________*Others:*______________________________