Advanced Radiology

Venous Center of Excellence History and Physical

Name:________________Date of Birth_____________Todays Date___________

Address________________________________City/State/Zip______________________

Phone_______________________How did you learn about us?___________________

1. What is your primary concern with the veins in your leg (s)?
2. Please circle any symptoms that you experience: R=Right L=Left

Aching	R	L	Fatigue	R	L
Pain	R	L	Burning	R	L
Heaviness	R	L	Throbbing	R	L
Cramping	R	L	Restless Legs	R	L
Itching	R	L	Swelling	R	L

3. How long have you been having symptoms?______________________________
   Have they been getting worse? Yes No

4. Have you tried any of the following?
   Over the counter support stockings/hose Yes No
   Prescription support stockings/hose Yes No
   If Yes: When did you start wearing them?___________________________
   Do they provide relief? Yes No
   Pain medication Yes No
   Elevating your legs Yes No
   Exercise Yes No

5. Do you have a job where you are required to stand long hours on your feet? Yes No
   Explain:____

6. Have you had your legs evaluated before? Yes No

7. Have you had previous surgery on your legs (ie vein stripping or sclerotherapy injections)?
   Yes No Explain:____

8. Who is your Primary care Physician?_______________________________________

9. Please list your medications:____

____

10. Please list any allergies you have:__________________________________

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Patients Name:______________________________

Please list any medical illnesses or disease you have:__________________________________

____

Please list any surgeries you have had:____

____

Please list any family history: (ie varicose veins, deep vein thrombosis, pulmonary emboli)

____

Please tell us about your history:

Do you smoke? Yes No
--If yes how long have you been a smoker?_____________
--How many cigarettes in a day?____________

Please circle one: Married Singles Divorced Widowed

Do you have children? Yes No How many?_______

What is your profession?____

Do you have any of the following? Please circle

Fever	Coronary artery disease	Diarrhea
Chills	High blood pressure	Constipation
Unintentional weight loss	Dizziness	Peptic Ulcers
Nights sweats	Fainting	Hepatitis
Decreased Vision	Asthma	Thyroid dysfunctions
Decreased hearing	Chronic obstructive lung disease	Diabetes
Sinus trouble	Shortness of breath	History of blood clots
Sore throat	Cough	Bleeding disorder
Chest pain	Abdominal pain	Palpitations

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Nurses to complete:

Blood Pressure:______________	Right GSV	Reflux	Yes	No
Pulse:_____________________	Right LSV	Reflux	Yes	No
Respirations:________________	Left GSV	Reflux	Yes	No
Temperature:________________				

Notes: