MequonVein

MEQUON VASCULAR ASSOCIATES, SC

PATIENT HISTORY FORM

PATIENT NAME: _____

DOB: _____

DATE: _____

Please let me know how you heard of me: Doctor_____

Family/Friend_____ ☐ Brochure ☐ Other

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1) How many months or years have you had problems with leg veins?

_____ months _____ years

Circle any symptoms that you have from your legs:

Pain Ache Swelling Tired Fatigue Itching Ankle Swelling Cramps Numbness

Restless Legs Throbbing Burning Bleeding Ulcer (poor healing areas of skin)

Heaviness Other:_____

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2) Is your ability to fall asleep delayed by vein symptoms? Yes No

If yes, does this occur: Nightly Frequently Sometimes Rarely Never

On average, how many minutes or hours does it take you to fall asleep when your legs are bothering you? _____ minutes _____ hours

On average, how many minutes or hours does it take you to fall asleep if awakend by leg symptoms? _____ minutes _____ hours

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3a) Can your leg symptoms start if you have been sitting or driving for an extended amount of time? ☐ Yes ☐ No

If yes, on average, how many minutes or hours does it take your symptoms to start?

_____ minutes _____ hours

What do you do to try and lessen these symptoms? (circle all that apply)

Elevate legs Stand Walk Wear stockings Pain medicine Other _____

Can your leg symptoms start if you have been standing or walking for an extended period of time? ☐ Yes ☐ No

If yes, on average how many minutes or hours does it take for your symptoms to start? _____ minutes _____ hours

What do you do to lessen the symptoms? Circle all that apply

Elevate legs Sit down Lay down Wear stockings Pain medicine

Other: _____

3b) Please check box if appropriate:

☐ An employer has been unhappy with my need to make adjustments for my leg symptoms.

☐ I have changed or avoided jobs because of my leg and/or vein symptoms.

☐ My leg symptoms make it more difficult to complete routine activities near the end of the day

☐ I have had to make adjustments at work or during my daily routine because of my leg symptoms.

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4) I have had_____number of episodes of hard, painful, red bumps lasting for approximately 1-2 weeks over the areas where veins are in my legs.

This has caused: (circle all that apply)

Sick days ER visit Doctor office visits Prescription strength pain medicine

Hospitalization Work restrictions

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5) Have you had unexplained bruising on your legs? Yes No

I have had _____separate episodes of bleeding from my veins.

When this happened I: (circle all that apply)

Passed out Felt dizzy Felt light-headed

To treat this I had to go to the: (circle all that apply)

Emergency department Doctor office I treated this on my own at home

To treat my symptoms I was given: ☐ IV fluids ☐ Blood transfusion

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6) I have had sore(s) on my legs that have not healed or take a long time to heal. Yes No

If yes, the sore(s) have been present for _____months or _____ years.

I have seen my primary care doctor to try to heal this area. Yes No

I have seen a specialist to try to heal this area. Yes No

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7) What number of months or years ago was the first time you elevated your legs to try and reduce leg symptoms?_____months ago_____years ago. (give best estimate)

I have taken _____to try and relieve leg discomfort. (circle all that apply)

Tylenol Ibuprofen Advil Motrin Naproxen Aleve Diuretics

other_____

What number or months or years ago was the first time you used one of these medicines?

_____months _____years (give best estimate)

The medicine ☐ is not ☐ is somewhat ☐ is very helpful in relieving my leg discomfort.

8) Have you used prescription compression stockings before? Yes No
If so, what number of months or years ago was the first time you wore them?
_____months _____years. (give best estimate)

How often do you wear them now? Daily When needed Never

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9) Has a doctor treated your veins before? Yes No

If yes, with what method? (circle all that apply) Stockings Injections Laser Surgery

How long ago?_____

Have you had any prior ultrasound studies of your legs in the last 6-12 months? Yes No

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10) Please check the box if you have had or currently have any of the following:

- ☐ Leg ulcer (sore)
- ☐ Heart by-pass surgery
- ☐ Blockage in an artery or vein
- ☐ Leg Trauma
- ☐ Congestive heart failure
- ☐ Phlebitis
- ☐ Bleeding from veins
- ☐ Stroke/ mini stroke
- ☐ Lymphedema
- ☐ Excessive bleeding after a surgery or procedure
- ☐ Easy scarring
- ☐ Blood clot or clotting disorder
- ☐ Family history of blood clot or clotting disorder
- ☐ Blood clot in lungs
- ☐ Diabetes
- ☐ Nerve pain from diabetes
- ☐ # of Pregnancies
- ☐ Planning a pregnancy or Pregnant within last 6 months
- ☐ Breast feeding
- ☐ Pain, weakness, arthritis that limits walking
- ☐ Foot and/or Lower leg surgery
- ☐ Other_____

Family member(s) with varicose or spider veins? Yes No

Who?_____ _____

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12) Have you ever smoked tobacco? Yes No

If you answered yes, have you quit smoking? Yes No

Medications you currently take: _____

_____

Medicine allergies or bad reactions to medication? _____

_____

Dr. Sabatino and his staff thank you for filling out this questionnaire. It greatly helps us to make an accurate diagnosis and tailor a treatment plan that we feel is best for you.