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Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Referring Physician \_\_\_\_\_

Which of your legs has problems? Right \_\_\_\_\_ Left \_\_\_\_\_

Symptoms-aching pain swelling itching fatigue heaviness throbbing  
Other \_\_\_\_\_

How long have these symptoms been present? \_\_\_\_\_  
Are they worse after prolonged standing? \_\_\_\_\_ Yes/No

Do you feel that your varicose veins interrupt your lifestyle? \_\_\_\_\_ Yes/ No  
If so how? \_\_\_\_\_

Have you at any time worn prescription compression stockings? \_\_\_\_\_ Yes/No  
If so how long did you wear them. \_\_\_\_\_  
Did they help your symptoms? \_\_\_\_\_ Yes/No

Have you at any time taken pain medications to relieve your symptoms? \_\_\_\_\_ Yes/ No  
Please list \_\_\_\_\_

Have you ever had venous stasis ulcers or chronic leg wounds? \_\_\_\_\_ Yes/No  
If so when? \_\_\_\_\_

Have you ever had blood clots? \_\_\_\_\_ Yes/No  
If so how long ago? \_\_\_\_\_ Have you been treated with blood thinners? \_\_\_\_\_ Yes/ No

Have you ever had varicose vein surgery or previous vein treatments? \_\_\_\_\_ Yes/No  
If so describe? \_\_\_\_\_

Have you been pregnant? \_\_\_\_\_ Yes/ No  
How did pregnancy affect your veins? \_\_\_\_\_

Does your occupation require you to stand for prolong periods of time? \_\_\_\_\_ Yes/No

Do other family members have varicose veins? \_\_\_\_\_ Yes/No  
Who? \_\_\_\_\_

Please list all allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medical problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any problems with anesthesia?

Yes No

If so, what problems? \_\_\_\_\_

**FAMILY HISTORY:**

(Relation to family members with the following)

STROKE	Yes	No	_____
HIGH CHOLESTEROL	Yes	No	_____
CANCER	Yes	No	_____
HEART DISEASE	Yes	No	_____
BLOOD CLOTS	Yes	No	_____
BLEEDING PROBLEMS	Yes	No	_____
DIABETES	Yes	No	_____
HIGH BLOOD PRESSURE	Yes	No	_____

**SOCIAL HISTORY:**

Do you or have you ever smoked?

Yes No

If so, how long and quantity? \_\_\_\_\_

Date stopped? \_\_\_\_\_

Do you drink alcohol?

Yes No

If so, how often? \_\_\_\_\_

Do you use recreational drugs?

Yes No

If so, what have you used? \_\_\_\_\_

## REVIEW OF SYSTEMS

**\*\*\*Check any of the problems you have and explain below\*\*\***

General:  Recent weight change  Fever  Chills  Night Sweats

Other: \_\_\_\_\_

HEENT:  Headache  Glaucoma  Visual changes  Dentures

Hearing Aids  Hearing loss  Nose Bleeds  Sore throat

RESPIRATORY:  Asthma  Pneumonia  Shortness of Breath  COPD

Other lung problems: \_\_\_\_\_

CARDIOVASCULAR:  Chest Pain  High Blood Pressure  Heart Failure

Heart Attack  Heart Murmur

Other heart problems: \_\_\_\_\_

GASTROINTESTINAL:  Nausea  Vomiting  Diarrhea  Constipation

Stomach Ulcer  Heartburn  Difficulty swallowing

GENITOURINARY:  Frequent urination  Bloody urine  Kidney stones

Kidney failure  Infection  Prostate problems

GYNECOLOGICAL:  Number of pregnancies  Contraception/Estrogen Therapy

Date of Last menstrual period \_\_\_\_\_

ENDOCRINE:  Diabetes  Thyroid Problems  Excessive Sweating

Excessive Thirst  Excessive Dry skin  Cold/heat intolerance

MUSCULOSKELETAL:  General Weakness  Arthritis  Joint Pain

Fibromyalgia  Gout

NEUROLOGICAL:  Nerve Problems  Stroke  Seizure  Dizziness

HEMATOLOGIC/VASCULAR:  Bleeding Problems  Prior blood clots

Blood Disorder  Cancer/Tumors

Any unhealed sore or abrasion  Swelling

Stasis Ulcer  Varicose Veins

PSYCHOLOGICAL:  Depression  Anxiety/panic disorder  Nervousness

Claustrophobia

\*\*\*Explanation of above Responses:

\_\_\_\_\_  
\_\_\_\_\_