

# VEIN CENTER - NEW PATIENT HISTORY

DATE:  
NAME:  
SS#:  
DOB:  
MD:

### What kind of vein problem do you have?

Spider vein / varicosity / bleeding / swelling / inflammation / blood clot / ulcer or infection /

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### Where is it located?

Left - right / foot / calf / knee / thigh / hip/

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### What does it feel like to you?

No pain / pain / burn / throb / sting / ache / heavy / fatigue / itch / cramp / hot / red / swell

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### How severe is it?

Continuous / occasional / mild / moderate / severe

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### How long has it been going on? \_\_\_\_\_ years.

Or since: pregnancy / accident / occupation / DVT / operation

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### What brings it on?

Standing / sitting / working / walking / menses

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### How does it affect your life?

I am unable to: Sleep / work / stand / play /

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### What makes it better?

Resting / elevation / pain pills / support hose /

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### Have you worn compression hose for the last 6 weeks? Please circle Yes or No

### Please indicate if any problem is significant to you:

Constitutional: fever-chills / weight loss-gain / fatigue  
Head: headache /  
Eyes: vision change /  
ENT: sore throat / voice change  
Neck: masses / pain  
Respiratory: cough / wheeze / short of breath / sputum  
Cardiac: chest pain / palpitations

GI: pain / swelling / nausea-vomiting / change of bowel habits

GU: painful urination

Musc-skel: joint pain / arthritis

Breast: lumps

Skin: rash / dermatitis

Neuro: weakness / seizure / loss of consciousness

Psych: depression / anxiety

Endocrine: heat or cold intolerance

Hematologic: disorder of bleeding-clotting

**Please circle if you have ever had any of the following:** heart disease / high blood pressure / diabetes / thyroid condition / hepatitis / AIDS or HIV / acid reflux / cancer / lung disease / blood clots / kidney disease or dialysis  
other: \_\_\_\_\_

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**Please indicate any allergies:** latex / iodine / medicine

other: \_\_\_\_\_

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### Please indicate any operations or procedures:

heart bypass / cardiac cath / angioplasty or stent / gallbladder / appendix / thyroid / C-section / hysterectomy

other: \_\_\_\_\_

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### Please indicate any prior vein treatments:

vein stripping / sclerotherapy

other: \_\_\_\_\_

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### Is there a family history for illness?

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### Cigarette use: never

current smoker for \_\_\_\_\_ years

former smoker - quit \_\_\_\_\_ (when)

### Alcohol use: daily / socially / never /

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### Do you use any drugs? Yes or No

### Your occupation:

\_\_\_\_\_ NURSE \_\_\_\_\_ MD \_\_\_\_\_ DATE