New Patient Form: Varicose Veins/Peripheral Arterial Disease

Patient Name: _____**Client Number:**_____

Date: _____/_____/_____ **Date of Birth:** _____/_____/_____

Directions: Please answer the following questions. Provide estimates for dates of occurrence.

1. Why are you here today? _____
2. How did you hear about us? _____
3. Name, address and telephone number of your primary care provider.

   _____
4. Do you experience any of the following in your legs? **Please Circle**

Aching/pain?	Yes	No	Left Leg	Right Leg	Both
Heaviness?	Yes	No	Left Leg	Right Leg	Both
Leg fatigue?	Yes	No	Left Leg	Right Leg	Both
Itching/burning	Yes	No	Left Leg	Right Leg	Both
Leg swelling?	Yes	No	Left Leg	Right Leg	Both
Leg pain with walking?	Yes	No	Left Leg	Right Leg	Both
Leg cramps?	Yes	No	Left Leg	Right Leg	Both
Foot pain at night?	Yes	No	Left Leg	Right Leg	Both
Restless legs?	Yes	No	Left Leg	Right Leg	Both
Throbbing?	Yes	No	Left Leg	Right Leg	Both
Skin Discoloration?	Yes	No	Left Leg	Right Leg	Both
Skin/hair changes?	Yes	No	Left Leg	Right Leg	Both
Ulcer now or in the past?	Yes	No	Left Leg	Right Leg	Both
Varicose or spider veins?	Yes	No	Left Leg	Right Leg	Both

   Other: _____
5. How long have you had these symptoms? _____
6. Have your symptoms gotten **better** or **worse** in the past 6 months? _____
7. How far can you walk before your symptoms begin to bother you? _____
8. What helps the symptoms improve? **(Please Circle all that apply)**

   Leg elevation Tylenol or Ibuprofen Walking

   Stopping and resting Compression Stockings

   Other_____
9. What makes the symptoms worse: **(Please Circle all that apply)**

   Leg elevation Walking Climbing stairs or walking inclines

   Stopping and resting Compression Stockings

   Other_____
10. Are your symptoms **better** or **worse** by the end of the day? _____

11. Overall, how much of an impact do your symptoms have on your personal or work life?

    (None) 0 1 2 3 4 5 **(Severe)**
12. Have you ever had an ultrasound test done on your legs? Yes No

Patient last name: _____ **DOB:** _____**Medical Record Number:**_____

If yes, when, where, and which leg?

_____

13. Describe any treatments, procedures or surgeries you have done to help relieve this problem.

_____

_____

SOCIAL HISTORY:

14. Current or previous Occupation: _____

15. How many hours do you: stand during the day?: _____ sit during the day? _____

16. (WOMEN ONLY) Number of pregnancies: _____ Number of live births: _____

17. Exercise per week: ☐ None ☐ 1-5 hours ☐ 5-10 hours ☐ more than 10 hours

Type of exercise: _____

18. Tobacco use:

☐ Never ☐ Quit If so, when? _____

☐ Current: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew

Amount per day: _____ Number of years: _____

19. Alcohol: ☐ Never ☐ Social ☐ Occasionally ☐ Daily

20. Recreational Drug use: ☐ Never ☐ Social ☐ Occasionally ☐ Daily

SURGICAL HISTORY: (Please include any major operations you have had)

_____

_____

_____

_____

FAMILY HISTORY:

Please indicate whether there is a family history of any of the following:

	Circle as many as apply		
□ Aneurysm	Mother	Father	Brother/Sister
□ Diabetes	Mother	Father	Brother/Sister
□ Heart disease ☐ or heart attack	Mother	Father	Brother/Sister
□ Peripheral vascular disease	Mother	Father	Brother/Sister
□ Stroke	Mother	Father	Brother/Sister
□ Vein disease ☐ Varicose veins	Mother	Father	Brother/Sister

Patient last name: _____ **DOB:** _____**Medical Record Number:**_____

MEDICAL HISTORY: **Height:** _____feet _____inches **Weight:** _____pounds

Please indicate whether you have a history of any of the following:

Eyes: ☐ No problems
☐ Temporary Vision Loss
☐ Other_____

Ear/Nose/Throat: ☐ No problems
☐ Other_____

Cardiac: ☐ No problems
☐ High blood pressure
☐ Heart attack
☐ Heart stents
☐ Irregular heart beat
☐ Other_____

Endocrine ☐ No problems
☐ Diabetes
☐ Goiter
☐ Hyperthyroid
☐ Hypothyroid
☐ Other_____

Gastrointestinal: ☐ No problems
☐ Bleeding
☐ Liver disease
☐ Ulcer
☐ Other_____

Neurological: ☐ No problems
☐ Stroke ☐ TIA
☐ Arm or leg weakness
☐ Other_____

Vascular: ☐ No problems
☐ Blood clot or deep vein thrombosis (DVT)
☐ Bypass surgery
☐ Leg stent(s) Right Left Both
☐ Leg swelling Right Left Both
☐ Peripheral arterial disease
☐ Phlebitis (inflammation or infection of the veins)
☐ Varicose veins

Musculoskeletal: ☐ No problems
☐ Joint Pain
☐ Back Pain
☐ Leg trauma or surgery
☐ Other_____

Respiratory: ☐ No problems
☐ Asthma
☐ COPD ☐ Emphysema ☐ TB
☐ Lung clot or pulmonary embolism (PE)
☐ Other_____

Genitourinary: ☐ No problems
☐ Kidney disease
☐ Sexual dysfunction/Impotence
☐ Other_____

Hematological/ Lymphatic: ☐ No problems
☐ Blood clotting problems/disorders
☐ Blood borne such as HIV/AIDS
☐ Blood borne such as Hepatitis B or C
☐ Cancer, type_____
☐ Other_____

Psychological: ☐ No problems
☐ Anxiety
Depression
Other_____

Additional comments:

_____

_____

_____

_____

Patient last name: _____ **DOB:** _____**Medical Record Number:**_____

☐ Vein stripping Right Left Both _____
☐ Vein ablation Right Left Both
Other_____ _____

ALLERGY HISTORY: ☐ No known allergies

Allergies including medications, dye, iodine, shellfish, latex, and your reaction.

Allergy	**Reaction**	**Allergy**	**Reaction**
Allergy	**Reaction**	**Allergy**	**Reaction**

MEDICATIONS: ☐ None

Medications including over the counter, herbals and supplements.

Medication Name:	Dosage	Frequency

Physical Exam: **(PRACTITIONER USE ONLY)**

CEAP Classification: _____

Exam Findings: _____
_____
_____

CEAP CLASSIFICATION

C 0 – No evidence of venous disease
C 1 – Superficial spider veins
C 2 - Simple varicose veins only
C 3 – Edema
C4a – Skin pigmentation & eczema
C4b - Lipodermatosclerosis
C 5 – A healed venous ulcer
C 6 – An open venous ulcer