VEIN AND VASCULAR CENTERS, SC

Name: _____Age:_____Sex: M F Date:_____.

Contact Phone:_____Date of Birth:_____.

Address_____

City _____ State ____ Zip Code _____

Cell Phone _____ Email _____@_____

Spouse's Name _____ Spouse's DOB _____

Emergency Contact _____Phone _____ Relationship _____

Primary Insurance _____Secondary Insurance _____

Primary Doctor _____ How did you hear about us? _____

7 N. Grant Street Hinsdale, IL 60521 Ph: 708-354-8881 Fax: 708-354-8340 www.ChicagoLegs.com

VEIN AND VASCULAR CENTERS, SC

The reason why you are here today

_____

_____

_____

_____.

History of Present Illness

Where is the pain and or problem? _____

How severe is the pain/problem? 5 being most severe _____

When does this pain/problem occur? _____

How long have you had this pain/problem? _____

What other symptoms are you having? _____

Current Medical History

1. Do you experience any of the following in your legs:

Symptom	Yes	No
• Aching/pain		
• Heaviness		
• Tiredness/fatigue		
• Itching/burning		
• Swollen ankles		
• Leg cramps		
• Restless legs		
• Other		
• Throbbing		

2. Have your veins gotten worse in recent months Yes No
3. Do you elevate your legs to relieve discomfort? Yes No
4. Do you wear support hose prescribed by a doctor Yes No
   If yes, what type?_____
5. Do you wear light support hose (e.g. sheer energy)? Yes No
6. Do they provide relief? …… Yes No
7. Do you have any problems walking? Yes No
   If yes, how does it affect you? _____
8. Do you stand much at work? …… Yes No
   at home? …… Yes No
9. How does this standing affect your legs?
   _____
10. Have you ever had your veins evaluated before? Yes No
    If so, when and where?_____
11. Have you ever had any test(s) done on your veins? Yes No
    When and where _____

Family History

Does anyone in your family have varicose veins, spider veins, leg ulcers, or swollen legs?

Father ……Yes No Mother …….. Yes No
Brother……Yes No Sister……..…Yes No

Medications

1. Do you have any allergies (medicines, food, pollen, shrimp or shellfish, iodine IVP dye?) Yes No
   Please list them and briefly describe your reaction (e.g. rash, hives, shortness of breath, etc.)
   _____
   _____
   _____

2. Are you presently taking any medication including prescription and/ or non-prescription for your leg pain? (Over-the-counter) medicines Yes No

3. Do you take any blood-thinning medication?
   Yes No

4. Are you taking hormones or birth control pills?
   Yes No

Please list any and all medications that your are currently taking.

_____

_____

_____

_____

_____

_____

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	Yes	No
1. Have you ever been in the hospital as a patient. If yes, for what reason		
If yes, for what reason		
2. Have you ever had surgery? If yes, for what reason		
3. Have you ever had vein stripping surgery. If yes, when and which leg?		
4. Have you ever had vein injections? If yes, when, where, and which leg?		
5. Are you presently under the care of a physician? If yes, for what illness or purpose?		
6. Have you ever had a blood clot? If yes, which leg and when?		
7. Have you ever had phlebitis? If yes, which leg and when?		
Women Only: Are you …	**Yes**	**No**
Pregnant or think you may be?		
Nursing (breast-feeding)?		
Taking oral contraceptives?		
Taking hormone replacements?		

Past Medical History

Do you have or have you had any of the following problems?

High Blood Pressure	Yes	No
Cardiac Pacemaker, Heart Disease/ Murmur		
Rheumatic Fever		
Leg Ulcers		
Stroke		
Diabetes		
HIV Infection		
Glaucoma/ Eye problems		
Stomach /Bowel Problem/ GI		
Recent Weight Loss		
Keloids/excessive scar		
Birth Defects		
Arthritis / Gout / Artificial Joints		
Bleeding Tendency/Anemia		
Cancer		
Liver disease or hepatitis		
Hay Fever/Allergies		
Seizures, Ears, Nose, Throat, Neurologic		
Kidney/Bladder Problem		
Asthma or Lung Problems		
Thyroid		

Social History: Please Circle

Marital status: Single Married Divorced

Widowed Separated

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously, but quit:

_____ Current packs/day _____

Patient Name: _____

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