

# Maryland Vein Professionals LLC

New Patient History Form Please complete all areas.

Name \_\_\_\_\_  
Date \_\_\_\_\_  
How Heard \_\_\_\_\_  
Primary Doc \_\_\_\_\_

## Pregnancy History

No Pregnancies       How many? \_\_\_\_\_  
 First Noticed Veins       Veins worsened

## I) Vein Health History

Current Age \_\_\_\_\_  
Veins Problematic for \_\_\_\_\_ years

### First Symptoms

Varicose Veins       Both     R     L  
 Pain                       Both     R     L  
 Swelling                 Both     R     L  
 Other \_\_\_\_\_

### Current Symptoms

Aching                       Both     R     L  
 Swelling                     Both     R     L  
 Fatigue                     Both     R     L  
 Itching                      Both     R     L  
 Burning                     Both     R     L  
 Throbbing                 Both     R     L  
 Tingling                   Both     R     L  
 Ulcers                       Both     R     L  
 Restless Legs             Both     R     L  
 Bleeding                   Both     R     L  
 Phlebitis                  Both     R     L  
 Dermatitis                 Both     R     L  
 Skin Color Change       Both     R     L  
 Other \_\_\_\_\_

### Symptoms Interfere with My Daily Life:

Work                       Air Travel  
 Leisure Activity         Long Car Travel  
 Routine Activity         Childcare

**IMPORTANT:** Give example(s) of above

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

### Blood Clots

DVT                               Both     R     L  
 Phlebitis                       Both     R     L

### Occupation \_\_\_\_\_

Prolonged  Sitting     Standing     Both

### Prior Vein Treatments

Date

Sclerotherapy     Both     R     L \_\_\_\_\_  
 Laser                       Both     R     L \_\_\_\_\_  
 Stripping                 Both     R     L \_\_\_\_\_  
 Phlebectomy         Both     R     L \_\_\_\_\_  
 Closure                     Both     R     L \_\_\_\_\_  
 Other \_\_\_\_\_

## II) Conservative Measures Attempted to

### Control Symptoms

#### \* Compression Stocking Use

First used \_\_\_\_\_ years ago  
 Use Currently  
Strength  15-20     20-30     30-40  
 Used with \_\_\_\_\_  
(ie., Other Vein Treatments, Pregnancy, Surgery, Work, Exercise)  
 Who Suggested \_\_\_\_\_  
Period of past use \_\_\_\_\_  months     yrs  
*(\*At least three months recent current stocking use is required for Closure preauthorization for most insurances)*

### Do You Have Symptom Relief with :

**Elevation**     Yes     No     Partial  
**Anti-Inflam. Med**     Yes     No     Partial

### I have attempted weight reduction :

Yes     No     Not an issue

### I exercise:

Daily                       \_\_\_\_\_ Times per week  
 Weekly                     No regular exercise

**II) General Medical History**

**Medications**    None

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

**Medication Allergies**

None    Yes

If Yes, to what?                      Type of Reaction

\_\_\_\_\_

**Prior reaction to Lidocaine, Novacaine, Iodine, or Latex?**

None    Yes

If Yes, to what?                      Type of Reaction

\_\_\_\_\_

**Past or Current Medical Conditions**

No other problems

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

**Surgeries/Dates**    None

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

**Family with Varicose Veins**

Mother    Father

Others \_\_\_\_\_

Treatments? \_\_\_\_\_

**Social History**

Marital Status    S    M    D    W

Smoking    Never    Quit \_\_\_ Yrs ago

Yes \_\_\_ Pks/d

Alcohol    Never    Social    Moderate

**Review of Systems** (*circle if yes*)

**Head & Neck**    No Complaints

Migraines    Glasses    Sinusitis    Dental

**Respiratory**    No Complaints

Asthma    Emphysema    Bronchitis

**Cardiac**    No Complaints

Angina    Murmur    High BP

**Gastrointestinal**    No Complaints

Ulcer    Reflux    IBD    Diverticulosis

**Genitourinary**    No Complaints

UTIs    Frequency

**Extremities**    No other Complaints

Arthritis \_\_\_\_\_

**Neuropsych**    No Complaints

Anxiety    Depression    Neuropathy

**Endocrine**    No Complaints

Diabetes    Thyroid \_\_\_\_\_

**Hematological**    No Complaints

Lupus    Clotting Disorder \_\_\_\_\_

**PLEASE SIGN BELOW:**

**The above is true to the best of my knowledge** \_\_\_\_\_