Vein Patient Assessment

DATE _____

NAME _____ DOB_____

SEX: M F HEIGHT: _____WEIGHT: _____REFERRED BY: _____

WHICH LEG ARE YOUR COMPLAINTS LOCATED IN? (check one) ☐ Right ☐ Left ☐ Both

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (check all that apply)

- □ Aching
- □ Awakened at night
- □ Bleeding from veins
- □ Bulging
- □ Burning
- □ Cramping
- □ Difficulty healing wounds
- □ Edema
- □ Fatigue
- □ Heaviness
- □ Itching
- □ Painful
- □ Restless Legs
- □ Swelling
- □ Tenderness
- □ Throbbing
- □ Ulcers
- □ Varicose Veins
- □ Spider Veins
- □ Skin discoloration
- □ Other: _____

HOW WOULD YOU RATE THE SEVERITY OF YOUR SYMPTOMS?

- □ None
- □ Mild - Occasional not restricting activity or requiring analgesics
- □ Moderate - Daily, moderate activity limitation, occasional analgesics
- □ Severe - severe limiting activities or requiring regular use of analgesics

HOW LONG HAVE YOUR SYMPTOMS BEEN BOTHERING YOU? (Fill in a number)_____ Weeks _____ Months

WHEN DO YOUR SYMPTOMS OCCUR? CHOOSE THE BEST ANSWER BELOW. (Check one)

□ Morning □ Afternoon □ Evening □ Night Other: _____

DO YOUR SYMPTOMS AFFECT YOUR ACTIVITIES OF DAILY LIVING? **This will assist with Insurance approval**

Yes or No

***If yes, which activities are affected*:** (check all that apply)

- □ Exercise
- □ Unable to walk hills
- □ Walking long distances
- □ Walking short distances
- □ Unable to stand Long
- □ Unable to sit long
- □ Unable to work
- □ Homemaking
- □ Sex life
- □ Travel
- □ Sleep / Relaxation
- Other: _____

ARE YOUR SYMPTOMS WORSENED BY: (check all that apply)

□ Prolonged Standing	□ Walking	□ Heat	□ Premenstrual	□ Travel	□ Working
□ Prolonged Sitting	□ Exercise	□ Hot Bath	□ Pregnancy	□ Resting	□ Other:

PREMIER VEIN OF ALASKA

Vein Patient Assessment

PLEASE MARK ANY CONSERVATIVE THERAPY MEASURES THAT YOU HAVE TRIED IN THE PAST TO RELIEVE YOUR SYMPTOMS: (check all that apply)

□ Compression stockings	□ Weight reduction	□ Cold soak	□ Walking
□ Leg elevation	□ Avoid prolonged sitting	□ Warm soak	□ Pain medications
□ Exercise	□ Avoid prolonged standing	□Other_____	

If yes to compression stockings:

Compression	How Long?	
□ Store bought	_____weeks	□ Night Only
□ 20 - 30 mm Hg	_____months	□ All Day
□ 30 - 40 mm Hg	_____years	

If yes to pain medications: (check all that apply)

☐ Rx Meds □ Aleve □ Ibuprofen □ Tylenol □ Aspirin

HOW OFTEN HAVE YOU USED MEDICATION? (check all that apply)

□Hourly	□ Daily	□ Weekly	□ Monthly
□0-2 days/wk	□ 3-4 days/wk	□ 5-6 days in 2 wk period	□ 7 > days in 2 wk period

WAS THERE RELIEF FROM SYMPTOMS WITH THE ABOVE CONSERVATIVE THERAPY MEASURES?

□Yes □ No □ Other_____

HAVE YOU HAD ANY VEIN TREATMENTS PERFORMED IN THE PAST? Yes or No
If yes, please list them below:

Previous Treatments:	Circle	Year	Doctor
□ Sclerotherapy/Injections	Right / Left	_____	_____
□ Phlebectomy/Stripping	Right / Left	_____	_____
□ Vein Ablation/ Closure (circle one) Laser or RFA	Right / Left	_____	_____
□ Treatment for leg cramps	Type: _____		
□ Treatment of ulcers, phlebitis, cellulitis or edema	Type: _____		

PREMIER VEIN OF ALASKA

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PAST MEDICAL HISTORY: (check all that apply)

□ Phlebitis
□ Varicose Veins
□ Spider Veins
□ Bleeding Veins
□ Leg Ulcers
Liver Disease
□ Leg Swelling/Edema
□ Blood Clots
□ Arterial Disease/Blockage
□ Bleeding Disorder
□ Other: _____

□ Cancer: _____
□ Radiation Therapy
□ CVA/Stroke
□ Hypertension

□ HIV/AIDS
□ Arthritis
□ Diabetes
□ Aneurysm

□ Muscular Disease
□ Hormonal Therapy
□ Currently Pregnant
□ Back Pain/Discomfort
□ Heart Problems □

□ Hyper/Hypothyroidism
□ Kidney Disease
□ Trauma/Injury to Leg
□ Arrhythmia

PAST SURGICAL HISTORY: (check all that apply)

□ Adenoidectomy
□ Colon Resection
□ Appendectomy
□ Gall Bladder
□ C-Section
□ Gastric Bypass

□ Lung Resection
□ Hernia Repair
□ Prostate
□ Hysterectomy
□ Tubal Ligation
□ Cardiac Bypass

□ Breast Biopsy/Mastectomy
□ Hip Replacement
□ Knee Replacement
□ Skin Cancer
□ Other: _____

Any surgical complications? _____

FAMILY HISTORY OF VARICOSE VEINS? Yes or No ***if yes, which family members*: (check all that apply)**

☐ Mother □ Father □ Siblings □ Grandmother □ Grandfather

FAMILY HISTORY OF CLOTTING DISORDER? Yes or No ***If yes, which family members*: (check all that apply)**

☐ Mother □ Father □ Siblings □ Grandmother □ Grandfather

SMOKING STATUS: □ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoked

If you are a current or former smoker, how many packs per day? _____
How long did you smoke regularly?_____years
At what age did you start smoking? years

FEMALES ONLY:

How many pregnancies have you had?___(number)
How many children have you had?___(number)

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PLEASE LIST ALL ALLERGIES: _____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (including Herbs, Vitamins, Supplements, etc.)

NAME OF MEDICATION	STRENGTH	REASON YOU ARE TAKING

PLEASE MARK ANY ADDITIONAL SYMPTOMS YOU ARE EXPERIENCING TODAY OR RECENTLY:

- □ Fatigue
- □ Fever
- □ Recent Weight Loss
- □ Recent Weight Gain
- □ Decreased Vision
- □ Disturbance of Vision
- □ Loss of Vision
- □ Chest Pain
- □ Palpitations
- □ Shortness of Breath While Walking
- □ Hemorrhoids
- □ Indigestion
- □ Jaundice
- □ Pain on Defecation
- □ Rectal Bleeding
- □ Vomiting of Blood
- □ Joint Pain
- □ Leg Cramps
- □ Night Cramps
- □ Easy Skin Bruising
- □ Anxiety
- □ Depression
- □ Insomnia
- □ Mood Swings
- □ Blood in Urine
- □ Difficulty Passing Urine
- □ Irregular Periods
- □ Pain/Burn Urination
- □ Pain w/Intercourse
- □ Pain w/Menstruation

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□ Shortness of Breath While Lying Flat □ Eczema □ Pelvic Pain