VARICOSE & SPIDER VEINS

Consultation

Patient Name______________________________
DOB______________________ Age__________
Consult Date______________________________
Primary Physician__________________________
Referring Source___________________________

***Patient to fill out:** Please checkbox or fill in the blank.

CURRENT SIGNS AND SYMPTOMS

1. I am consulting for:
   ❑ Symptomatic reasons ❑ Cosmetic reasons ❑ Both
2. I have problems with my? ❑ Right Leg ❑ Left Leg
3. My problems are? ❑ Above the knees ❑ Below the knees

4. Please checkbox the signs & symptoms you are experiencing

❑ Aching	❑ Itching	❑ Swelling
❑ Pain	❑ Burning	❑ Restless legs
❑ Throbbing	❑ Tiredness	❑ Skin Discoloration
❑ Cramping	❑ Heaviness	❑ Leg ulcers/skin erosion

❑ Other____________________________________

5. How many years have you noticed this problem?__________

ALLEVIATING / AGGRAVATING FACTORS

Y or N
❑ ❑ Have your veins gotten worse recently?
❑ ❑ Do you elevate your legs to relieve discomfort?
❑ ❑ Do you wear any type of support hose?____________
# of years____________
❑ ❑ Do you have any problems walking (how does it affect you?)______________________________
❑ ❑ Do you stand a lot at home or work?______________

PREVIOUS VEIN STUDIES / PROCEDURES

Y or N
❑ ❑ Have you ever had your veins evaluated before? When & where?________________________________
❑ ❑ Ever had vein stripping or ligation? (year & which leg)
____
❑ ❑ Ever had vein laser or radiofrequency procedure? (year & which leg)__________________________
❑ ❑ Ever had vein injections? (when, where, which leg)
____

PERTINENT PAST MEDICAL HISTORY

Y or N
❑ ❑ Blood clot(s)____________________________
❑ ❑ Clotting disorder________________________
❑ ❑ Easy bruising / bleeding____________________
❑ ❑ Phlebitis_______________________________
❑ ❑ Asthma________________________________
❑ ❑ Seizures_______________________________
❑ ❑ Heart murmur___________________________
❑ ❑ High blood pressure______________________
❑ ❑ Kidney disease__________________________
❑ ❑ HIV / Hepatitis_________________________
❑ ❑ Cancer________________________________
Other:______________________________________

FEMALE RELATED QUESTIONS

Y or N
❑ ❑ Do you think you are pregnant?
❑ ❑ Do you plan on having more children?
❑ ❑ Are you presently breast feeding?
LMP___________ ❑ Menopause ❑ Hysterectomy

FAMILY HISTORY

List family members with history of varicose / spider veins, leg ulcers, swollen legs, or blood clots.
____
____

SPECIFIC MEDICATION QUESTIONS

Y or N
❑ ❑ Are you hormone (estrogen) replacement?
____
❑ ❑ Are you on birth control?____________________
❑ ❑ Are you on blood thinners? (coumadin, aspirin, Plavix, etc.)______________________________
❑ ❑ Do you take antibiotics prior to medical or dental procedures?______________________________

*** FOR OFFICE USE ONLY***

RIGHT LEG

Shoe Size________
Ankle___________"
Calf____________"
Thigh____________"

❑ Spider Telangiectasias
❑ Reticular Telangiectasias
❑ Varicosities
❑ Lipodermatosclerosis
❑ Venous Stasis Hyperpig.
❑ Venous-related edema
❑ Venous Ulcerations
❑ Ankle Flaring

RIGHT LEG

LEFT LEG

Shoe Size________
Ankle___________"
Calf____________"
Thigh____________"

❑ Spider Telangiectasias
❑ Reticular Telangiectasias
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❑ Ankle Flaring

LEFT LEG

Ht:_____**ft**______**in**
Wt:_______**#**

❑ Photos taken

ASSESSMENT
1.
2.
3.

PLAN
1.
2.
3.
4.