The Vascular Experts
AESTHETICS

Name:______ Birth Date:______ Age:_____ Sex:___
Address:______ City______ St_____ Zip______
Phone: (Home)______ (Cell)______ (Work)______
SSN:______ Email:______ ☐ I do not wish to share my email
Language:______ Race:______ Ethnicity______ Occupation:______
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact:
Name:______
Phone:______ Relationship:______

Referring Physician:______
Phone:______

Primary Care Physician:______
Phone:______

Insurance Information:
PrimaryInsurance:______
ID:______ Group______
Policy Holder______
Employer______
Secondary Insurance:______
ID:______ Group______
Policy Holder______
Employer______

How did you hear about us? ☐ TV ☐ Radio ☐ Newspaper ☐ Mailer ☐ Social Media ☐ Website ☐ Dr. Referral ☐ Friend
Are you seeking treatment for: ☐ Cosmetic ☐ Medical reasons ☐ Both **Height:** _____ft _____in **Weight:** ______lbs

I: DESCRIBE YOUR VEIN PROBLEMS:

Please Rate symptoms **1-10**, 10 being the most severe:

Symptoms	Right Leg	Left Leg
Pain		
Achiness		
Restlessness		
Heaviness		
Burning		
Itching		
Night Cramps		
Swelling		
Bleeding		

Is your pain worsened by:
Heat Yes No
Menstrual Periods Yes No
Exercise Yes No
Prolonged standing Yes No
Prolonged sitting Yes No

Is your pain alleviated by:
Elevation of your legs Yes No
Compression stocking Yes No
Exercise/Walking Yes No

When do your symptoms occur?
☐ Day ☐ Night ☐ All day ☐ While laying down

Does your symptoms affect your activities? Yes No
If Yes, (check all that apply)
☐ Walking ☐ Sleep ☐ Exercise ☐ Sitting ☐ Standing

Please mark any conservative therapy measures that you have tried:
☐ Compression ☐ Stocking ☐ Exercise ☐ Walking
☐ Weight reduction ☐ Leg elevation ☐ Pain medications

Any relief? Yes No
From which______

Are your veins getting larger? Yes No

II: VENOUS HISTORY

When did your veins first occur? Age______
Before Pregnancy Yes No
After Pregnancy Yes No
After Trauma/Surgery Yes No

Do you have a history of:
DVT (deep vein blood clot) Yes No
SVT (superficial phlebitis) Yes No
Pulmonary embolism (PE) Yes No
Leg Swelling/Edema Yes No
Ulcer/nonhealing wound Yes No

Have you ever been treated for varicose veins or spider veins with:
Surgical vein stripping Yes No
Side: RT LT Yr:_____ Dr:______
Laser/Radiofrequency Ablation Yes No
Side: RT LT Yr:_____ Dr:______
Ambulatory phlebectomy Yes No
Side: RT LT Yr:_____ Dr:______
Sclerotherapy (Injections) Yes No
Side: RT LT Yr:_____ Dr:______
Topical Laser Therapy Yes No
Side: RT LT Yr:_____ Dr:______
Surgical Ligation Yes No
Side: RT LT Yr:_____ Dr:______

III: MEDICAL HISTORY

☐ Arrhythmia Yes No
☐ Asthma Yes No
☐ Hepatitis Yes No
☐ Atrial Fibrillation Yes No
☐ HIV/AIDS Yes No
☐ Arthritis Yes No
☐ Hypertension Yes No
☐ Atrial Disease Yes No
☐ Hormonal Therapy Yes No
☐ Autoimmune Disease Yes No
☐ Liver Disease Yes No
☐ Bleeding disorders Yes No
☐ Migraines Yes No
☐ Cancer Yes No
☐ Muscular Diseas Yes No
☐ Cardiac Disease Yes No
☐ Seizures Yes No
☐ COPD Yes No
☐ Trauma Yes No
☐ CVA/Stroke Yes No
☐ Thyroid disease Yes No
☐ Diabetes: Type 1___ Type2___ Yes No
☐ Renal disease Yes No

IV: SURGICAL HISTORY: (Please list below)

Surgery: **Date:**
1.______ ______
2.______ ______
3.______ ______
4.______ ______

V: PLEASE MARK ANY ADDITIONAL SYMPTOMS YOU ARE EXPERIENCING TODAY:

☐ Joint Pain ☐ Muscle Cramps ☐ Bruising
☐ Sleep Apnea ☐ Weight Change ☐ Insomnia
☐ Numbness ☐ Chronic cough ☐ Edema
☐ Visual Loss ☐ Limb Weakness ☐ Tingling
☐ Palpitations ☐ Easy Bleeding ☐ Fatigue
☐ Pruritus ☐ Dysphagia ☐ Nausea
☐ Headaches ☐ Skin Discoloration ☐ Seizures
☐ Sore throat ☐ Abdominal Pain ☐ Dizziness
☐ Epistaxis ☐ Dysuria ☐ Anxiety
☐ Chest pain ☐ Hematuria ☐ Fever
☐ Depression ☐ Shortness of breath ☐ Rash

VI: DO YOU HAVE A FAMILY HISTORY OF:

Family member:
Varicose veins ☐ Yes ☐ No ______
Clotting disorder ☐ Yes ☐ No ______

VII: DO YOU SMOKE? Yes No

If yes, how many packs a day ______

VIII: ARE YOU PREGNANT, PLANNING PREGNANCY SOON, OR BREAST FEEDING? Yes No

Have you ever had any miscarriages? Yes No
If yes, how many?______

IX: ALLERGIES:

Medications: Yes No
If yes, please list:______
Reaction:______
Latex Yes No
Iodine/betadine Yes No
Tape/adhesives Yes No
Other: ______

X: MEDICATIONS:

(Please list prescribed and over the counter)
Name of medications: **Dose:**
1.______ ______
2.______ ______
3.______ ______
4.______ ______