Vein Center
Phoenix Heart PLLC

Phoenix Heart PLLC
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Today's Date:	**HEALTH & HISTORY FORM**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

SYMPTOMS

Reason for your visit today: _____ **Years with Spider Veins or Varicose Veins:** _____

Please check if you have had or currently have any of the following in your legs or ankles:

☐ Hurt/Pain/Throb/Ache/Burn ☐ Tired/ Heavy Feeling ☐ Cramping ☐ Other: _____

☐ Leg Swelling ☐ Itch ☐ Restless Legs _____

Please check if you have had or currently have any of the following:

☐ Leg Swelling ☐ Skin Color Changes Below Knee ☐ Bleeding from the Visible Veins ☐ Other: _____

☐ Visible Veins ☐ Sores/ Ulcers Below Knee ☐ Blood Clots in your legs _____

Please tell us how your signs and symptoms **Negatively** affect your **daily life and activities**: (Please give us at least **TWO** examples) *Ex: Pain in legs while shopping, cooking, walking, running, working etc…*

Example: _____

Example: _____

Example: _____

Please tell us about any and all methods you have used to help with the discomfort in your legs:

☐ Elevation of Legs

☐ Exercise: Walking or running

☐ Use of: Tylenol / Ibuprofen / Advil *

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

☐ Other: _____

☐ Use of Support / Compression Stockings: * (Medical Grade)

☐ Given by Physician: _____ ☐ Over the counter

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

Type: ☐ Panty Hose ☐ Thigh High ☐ Knee High

Results: ☐ Minimal relief ☐ Moderate relief ☐ Significant relief

PAST VASCULAR MEDICAL HISTORY

Please tell us about an PREVIOUS VEIN TREATMENTS:

☐ Treatment done by: _____ ☐ What Clinic: _____

Treatment Method:

☐ Injections (Sclerotherapy) ☐ EVLT (laser procedure for Varicose Veins) ☐ Plebectomy (removal of veins)
☐ Laser for Spider Veins ☐ Stripping / Surgery ☐ Stents/ Filters: _____

☐ Other: _____

FAMILY VASCULAR MEDICAL HISTORY

☐History of DVT (Deep Vein Thrombosis / Blood Clots or Clotting disorder) ☐History of Varicose Veins

PT SIGNATURE: _____

MEDICATIONS / ALLERGIES / SURGICAL HISTORY

Please list all **MEDICATIONS** that you are currently taking with dosage: (☐ SEE LIST)

_____
_____
_____
_____

ALLERGIES:

☐ No Known Drug Allergies (NKDA) ☐ PCN **SKIN ALLERGIES:** ☐ Latex ☐ Skin Tape

☐ Drug Allergies: _____
_____

SURGERIES: (List with dates)

_____ _____
_____ _____
_____ _____
_____ _____

FOR WOMEN ONLY

☐ Date of last menstrual cycle: _____
☐ Trying to become pregnant
☐ Currently Pregnant (please inform medical staff)
☐ Breast Feeding
☐ Post Menopausal

☐ Number of Pregnancies: _____
☐ Number of Miscarriages/ Stillbirths: _____
☐ Veins on Vulva or Labia
☐ Pelvic Pain or Heaviness / Pelvic Congestion Syndrome
☐ Hysterectomy/Date: _____

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.

_____ _____

PT signature *Date*