Patient History (page 1)

ATLAS VEIN CARE

Patient Information

Patient Last Name:_____ First Name:_____ Date of Birth:_____

Primary Doctor:_____ Today's Date: _____

Referring Physician:_____

How did you hear about us?_____

Primary Insurance:_____ Identification #_____ Group #_____

Secondary Insurance:_____ Identification #_____ Group #_____

Vein Disease Questionnaire & History

We will use the information you provide to help us make the most appropriate recommendations for your care. Your insurance carrier may also use this information to judge whether your problems are "medically necessary," and to determine if you have already attempted to help your problems with conservative measures such as, exercise, periodic elevation, avoidance of prolonged standing, and wearing compression stockings.

Do you have any of these symptoms? (check all that apply)

☐ Varicose Veins	☐ Spider Veins	☐ Leg Fatigue	☐ Leg Heaviness
☐ Leg Pain	☐ Leg Aching	☐ Throbbing	☐ Night Cramps
☐ Restless Legs	☐ Ankle Swelling	☐ Skin Discoloration	☐ Non-Healing Ulcer
☐ Burning	☐ Cramping	☐ Bleeding from Veins	☐ Itching
☐ Pelvic Pain	☐ Other:_____		

Do you use pain medication for leg issues? ☐ Yes ☐ No If yes, how often?_____

Do you try to elevate your legs? ☐ Yes ☐ No If yes, how often?_____

Do you avoid prolonged standing? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Are you on a weight lost/management routine? ☐ Yes ☐ No If yes, how much weight lost?_____

How long have you lived with leg symptoms?_____ Have they worsened over time? ☐ Yes ☐ No

Have you ever worn compression stockings? ☐ Yes ☐ No

If Yes: Why did you wear them?_____

When did you wear them?_____

How long did you wear them?_____

How do your leg symptoms limit your daily life or work?_____

_____

Thomas E. Eidson, D.O.
2701 Matlock Road, Suite 103 | Arlington TX 76015 | **817-795-VEIN (8346)** | fax 817-717-1840 **www.atlasvein.com**

Patient History (page 2)

Have you been treated for your leg veins before? ☐ Yes ☐ No

If yes, by whom?_____ When?_____

By which of the following methods:

☐ Cosmetic injections ☐ Ultrasound guided injections ☐ Radiofrequency closure

☐ Laser catheter ablation ☐ Laser for spider veins ☐ Ligation

☐ Vein Stripping ☐ Ambulatory Phlebectomy ☐ I don't know

☐ Other:_____

What was your outcome?_____

What would you like to correct the most about your legs?_____

_____

Have you been or are you currently on blood thinners? ☐ Yes ☐ No If yes, for how long?_____

Please list your current medication(s):_____

_____

Please list the medications you are allergic to and your reaction to each medication:_____

_____

Do you have a history of:

Leg Ulcers ☐ Yes ☐ No Leg skin discoloration ☐ Yes ☐ No

Blood Clots ☐ Yes ☐ No Bleeding from veins ☐ Yes ☐ No

Please list any surgeries that you have had:_____

_____

Did you wear compression stockings after surgery? ☐ Yes ☐ No

Do you have a family history of varicose or spider veins? (check all that apply)

☐ Mother ☐ Father ☐ Siblings

☐ Children ☐ Maternal Grandparents ☐ Paternal Grandparents

Do you have a family history of blood clots? ☐ Yes ☐ No

Have you had any of the following medical illnesses? (check all that apply)

☐ COPD ☐ Blood transfusions ☐ High cholesterol ☐ HIV or AIDS

☐ Clot in lungs (PE) ☐ Stroke ☐ Arthritis ☐ Clot in legs (DVT)

☐ Kidney problems ☐ Asthma ☐ Hole in your heart ☐ High blood pressure

☐ Cancer ☐ Depression ☐ Bleeding Disorder ☐ Pacemaker

☐ Dialysis ☐ Hepatitis B ☐ Diabetes ☐ Migraines

☐ Hepatitis C ☐ Lupus ☐ Heart attack (MI) ☐ Thyroid Problems

☐ Anemia ☐ Epilepsy ☐ Goiter ☐ Gout

☐ Herpes ☐ Liver Disease ☐ Miscarriage ☐ Heart Disease

☐ Multiple Sclerosis ☐ Stroke ☐ Prostate Problems ☐ Rheumatic Fever

☐ Ulcers ☐ Tuberculosis ☐ Other:_____

ATLAS VEIN CARE

Social History

Occupation:_____ Employer:_____

Do your daily activities include prolonged periods of sitting and standing? ☐ Yes ☐ No

If yes, what is the activity that you are doing?_____

_____

Have you ever, or do you now use tobacco? ☐ Yes ☐ No

If yes, please explain:_____

If you quit (good for you!), when?_____

Average number of alcoholic beverages per week: ☐ None ☐ 1-5 ☐ 6-10 ☐ 10+

Females Only

Are you pregnant? ☐ Yes ☐ No

If yes, are you currently breastfeeding? ☐ Yes ☐ No

Are you planning on becoming pregnant soon? ☐ Yes ☐ No

Do you have leg discomfort around your menstrual cycle? ☐ Yes ☐ No

Number of children: _____ Number of miscarriages: _____

OFFICE USE ONLY

Blood Pressure:_____ Weight:_____ Height:_____

Calf Dimension:_____ Ankle Dimension:_____

VEIN EXAM

RIGHT LEG:					LEFT LEG:				
Varicose Veins	T	K	C		Varicose Veins	T	K	C	
Spider Veins	T	K	C		Spider Veins	T	K	C	
Edema	1+	2+	3+		Edema	1+	2+	3+	
Pitting	1+	2+	3+		Pitting	1+	2+	3+	
Ulcer	A	C	K	T	Ulcer	A	C	K	T
Lipodermatosclerosis	A	C			Lipodermatosclerosis	A	C		
Hemosiderosis	A	C			Hemosiderosis	A	C		
Atrophie Blanche	A	C			Atrophie Blanche	A	C		