

EVOLVES VASCULAR LAB

East Volusia's Optimal Lab for Vascular Evaluation & Surveillance

an affiliation of

Coastal Cardiovascular & Thoracic Associates, P.A.

VENOUS HEALTH HISTORY

1.3VL

NAME _____ AGE _____ ACCOUNT _____ DATE _____

REASON FOR VISIT/CHIEF COMPLAINT _____

PAST MEDICAL HISTORY (if yes, number of years and treatment)

Have you ever had vein stripping? NO YES when & which leg? _____

Have you ever had vein injections? NO YES which leg & what area? _____

Have you ever had a blood clot? NO YES when & which leg? _____

Have you ever had phlebitis? NO YES when & which leg? _____

OTHER RELATED MEDICAL PROBLEMS _____

FEMALES--ARE YOU PREGNANT? (circle one) YES / NO If yes, how far along? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOUR LEGS?

Aching/pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Heaviness	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Tiredness/fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Itching/burning	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Swollen ankles	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Leg cramps	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Restless legs	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Throbbing	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> One leg – <input type="checkbox"/> Left or <input type="checkbox"/> Right	<input type="checkbox"/> Both legs
Other	_____		

HAVE YOUR VEINS WORSENERD IN RECENT MONTHS? Yes No

If yes, explain: _____

DO YOU ELEVATE YOUR LEGS TO RELIEVE DISCOMFORT? Yes No

If yes, for how long and does it provide relief? _____

DO YOU EXERCISE? No Yes-what kind & how often? _____

DO YOU WEAR PRESCRIPTION COMPRESSION STOCKINGS? Yes No

If yes, who is physician who prescribed? _____ When were they prescribed? _____

What type & gradient? _____ How long have you worn them? _____

DO YOU WEAR LIGHT SUPPORT HOSE? (i.e., Sheer Energy) Yes No

If yes, explain how they provide relief, if any: _____

VENOUS HEALTH HISTORY

1.3VL

NAME _____ **ACCOUNT** _____ **DATE** _____

DO YOU HAVE ANY PROBLEM WALKING? Yes No

If yes, describe which daily activities and how it interferes: _____

WHAT TYPE OF WORK DO YOU DO? _____

How many hours per day do you stand at work _____ at home _____?

Do your symptoms interfere with your essential job function or occupation? Yes No

If yes, explain: _____

HAVE YOU HAD ANY PREVIOUS VENOUS TESTING PERFORMED? Yes No

If yes, what type & what area of your leg(s)? _____

WERE YOU DIAGNOSED WITH SAPHENOUS VEIN REFLUX? Yes No

If no, what was the exact diagnosis? _____

WHO IS YOUR REFERRING PHYSICIAN? _____

How long has the referring physician treated you for this condition? _____

SMOKE (circle one) YES / NO / Never Smoking/smoked how long? _____ mos _____ yrs Packs/Day _____

If quit, how long ago? _____ mos _____ yrs

ETOH/SUBSTANCE _____

MEDICATIONS (pertaining to venous diagnosis)

Type	dose/frequency	Type	dose/frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES _____

PHARMACY (name, location, phone) _____

FAMILY HISTORY: Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Mother Yes No **Father** Yes No **Brother(s)** Yes No **Sister(s)** Yes No **Other** Yes No

EMERGENCY CONTACT _____ **Relation** _____ **Phone** _____

(Below for office use only)

AUTHORIZATION TO RELEASE RECORDS TO BE COMPLETED if patient is authorizing *EVOLVES* or *Coastal Cardiovascular* to release information via telephone, facsimile or US Mail to family member, caretaker or friend (7.1 form). One form per person of note. _____

COMMENTS _____

VERIFIED BY (office use only) _____