EVOLVES VASCULAR LAB

East ***V***olusia's ***O***ptimal ***L***ab for ***V***ascular ***E***valuation & ***S***urveillance

an affiliation of

Atlantic Cardiovascular & Thoracic Surgeons, LLC

VENOUS HEALTH HISTORY

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	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Heaviness	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Tiredness/fatigue	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Itching/burning	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Swollen ankles	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Leg cramps	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Restless legs	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs
Throbbing	☐No	☐Yes	☐One leg – ☐Left or ☐Right ☐Both legs

Other ____

HAVE YOUR VEINS WORSENED 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

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 only)

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 _____________

LIVING WILL □No □Yes **ON FILE WHERE** ____

(Below for office use only)

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

COMMENTS____

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VERIFIED BY *(office use only)* ________________