

# MORRISON VEIN INSTITUTE

*Better Care. Better Results.*

## CONFIDENTIAL HEALTH & VASCULAR HISTORY: WOMEN

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Years with varicose / spider veins? \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

Referring Doctor: \_\_\_\_\_

Please check one:

#### Magazines

- AZ Foothills Magazine
- AZ Magazine
- MD News Magazine
- Perfectify Magazine
- Phoenix Magazine
- Phoenix Home & Garden Magazine
- Phoenix Woman Magazine
- US Airways Magazine
- Yes Style Guide

#### TV

- Channel 5 – CBS
- Channel 12 – NBC
- Channel 15 – ABC
- Infomercial

#### Radio

- KBAQ 89.5 FM
- KEZ 99.9 FM
- KJZZ 91.5 FM
- KTAR

#### Newspapers

- AZ Republic

#### Miscellaneous

- Yellow Pages
- Chamber of Commerce
- Friend/Patient

- Internet
- www.veindirectory.org
- Health Fair
- Other \_\_\_\_\_

### PRIMARY CARE INFORMATION

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### SYMPTOMS

Please check if you have:

- |   |  |
|---|--|
| <input type="checkbox"/> Red spider veins                   | <input type="checkbox"/> Abdominal veins           |
| <input type="checkbox"/> Skin discoloration below your knee | <input type="checkbox"/> Bulging veins             |
| <input type="checkbox"/> Purple veins                       | <input type="checkbox"/> Diagnosis of vein disease |
| <input type="checkbox"/> Ankle sores                        | <input type="checkbox"/> Flat bluish-green veins   |
| <input type="checkbox"/> Purple vein network                | <input type="checkbox"/> Other _____               |

Do your legs or ankles:

- |  |                       |
|--|-----------------------|
| <input type="checkbox"/> Ache or hurt?         | Please describe _____ |
| <input type="checkbox"/> Swell?                | Please describe _____ |
| <input type="checkbox"/> Cramp?                | Please describe _____ |
| <input type="checkbox"/> Become restless?      | Please describe _____ |
| <input type="checkbox"/> Become tired / heavy? | Please describe _____ |
| <input type="checkbox"/> Itch?                 | Please describe _____ |
| <input type="checkbox"/> Other?                | Please describe _____ |

**MEDICAL HISTORY**

Is there a history in your **FAMILY** of spider or varicose veins?

Describe which:

- Mother \_\_\_\_\_
- Father \_\_\_\_\_
- Grandparents \_\_\_\_\_
- Siblings \_\_\_\_\_
- Aunt/Uncle \_\_\_\_\_
- Child \_\_\_\_\_

Is there a history in your **FAMILY** of deep venous thrombosis, stroke or clotting disorders?

Describe which:

- Mother \_\_\_\_\_
- Father \_\_\_\_\_
- Grandparents \_\_\_\_\_
- Siblings \_\_\_\_\_
- Aunt/Uncle \_\_\_\_\_
- Child \_\_\_\_\_

Do **YOU** have a history of:

- Anemia
- Ankle skin changes
- Atherosclerosis
- Bleeding/blood disorder
- Chest pain discomfort
- Constipation
- Crohn’s disease, IBS
- Deep Vein Thrombosis/clot
- Diabetes, insulin dependent
- Easy bruising
- Heart disease
- Hepatitis
- HIV
- Hypertension
- Kidney disease
- Leg ulcers
- Liver disease
- Lupus
- Migraine headaches
- Migraine with Aura
- Mitral valve prolapse
- Pulmonary embolus
- Rupture of a vein
- Superficial thrombophlebitis
- Trauma to your legs
- Other \_\_\_\_\_

Have you ever been tested for or found positive for a PFO (Patent Foramen Ovale) or ASD (Atrial Septal Defect)? \_\_\_\_\_ Yes \_\_\_\_\_ No

**CURRENT MEDICAL INFORMATION**

Do you have allergies or sensitivities to medicines or tape? List all: \_\_\_\_\_

Are you being treated for any illnesses or conditions? \_\_\_\_\_ If so, what illness: \_\_\_\_\_

Please list **ALL** medicines that you take (prescription, non-prescription, vitamins, and herbal):

Are you pregnant or planning to be soon? \_\_\_\_\_

Are you currently breast feeding? \_\_\_\_\_

Do you have more leg discomfort on or around your menstrual period? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of stillbirths / miscarriages \_\_\_\_\_

## VASCULAR HISTORY

Please check any methods you have used to relieve your leg discomfort:

- |   |   |
|---|---|
| <input type="checkbox"/> No discomfort                  | <input type="checkbox"/> Warm soaks           |
| <input type="checkbox"/> Leg elevation                  | <input type="checkbox"/> Cold packs           |
| <input type="checkbox"/> Exercise                       | <input type="checkbox"/> Pain medications     |
| <input type="checkbox"/> Flexion/extension of your feet | <input type="checkbox"/> Aspirin              |
| <input type="checkbox"/> Walking                        | <input type="checkbox"/> Tylenol              |
| <input type="checkbox"/> Support hose                   | <input type="checkbox"/> Ibuprofen            |
| <input type="checkbox"/> Wraps                          | <input type="checkbox"/> Other methods: _____ |

What is the **earliest** date that you started taking pain medications for leg problems (aspirin, Tylenol, Ibuprofen, other pain meds) and what was the outcome? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*What is the **earliest** date that you wore medical support hose for your leg problems? \_\_\_\_\_  
\_\_\_\_\_

*\*Some insurance plans require that compression hose be worn 6 months prior to request for treatment.*

How have your daily activities been affected or limited by your leg problems? \_\_\_\_\_  
\_\_\_\_\_

Are you on your feet for long periods? \_\_\_\_\_ In what capacity? \_\_\_\_\_  
\_\_\_\_\_

Does walking/exercise relieve your discomfort or make it worse? \_\_\_\_\_

Have you been treated for your veins before? \_\_\_\_\_

By whom? \_\_\_\_\_ When? \_\_\_\_\_

What method?

- |   |  |
|---|--|
| <input type="checkbox"/> Cosmetic injections          | <input type="checkbox"/> Radiofrequency closure  |
| <input type="checkbox"/> Stripping                    | <input type="checkbox"/> Laser catheter ablation |
| <input type="checkbox"/> Ambulatory phlebectomy       | <input type="checkbox"/> Laser for spider vein   |
| <input type="checkbox"/> Ligation                     | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Ultrasound-guided injections |  |

What have your results been? \_\_\_\_\_  
\_\_\_\_\_

What about your legs would you now most like to correct? \_\_\_\_\_  
\_\_\_\_\_