MORRISON
VEIN INSTITUTE

Better Care. Better Results.

CONFIDENTIAL HEALTH & VASCULAR HISTORY: MEN

Name:_____Date:_____

Primary Care Physician:_____ Phone:_____

Referring Doctor:_____ Phone:_____

And/or other source of information……Please check one:

Magazines
- ❑ Phoenix Magazine
- ❑ Phx Home & Garden Magazine

TV
- ❑ Channel 12 - KPNX
- ❑ Channel 8 - PBS
- ❑ Channel 15-ABC

Radio
- ❑ KBAQ 89.5 FM
- ❑ KEZ 99.9 FM
- ❑ KJZZ 91.5 FM
- ❑ KTAR 92.3 FM

Newspapers
- ❑ AZ Republic

Miscellaneous
- ❑ Yellow Pages
- ❑ Friend/MVI Patient Name:_____
- ❑ Internet
- ❑ www.veindirectory.org
- ❑ Chamber of Commerce
- ❑ Facebook
- ❑ Yelp
- ❑ Other

Years with varicose/spider veins_____

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

_____

_____

SYMPTOMS

Please check if you have:
- ❑ Red spider veins
- ❑ Skin discoloration below your knee
- ❑ Purple veins
- ❑ Purple vein network
- ❑ Bulging veins
- ❑ Flat bluish-green veins
- ❑ Ankle sores/ulceration
- ❑ Abdominal veins
- ❑ Diagnosis of vein disease
- ❑ Ruptured vein
- ❑ Scrotal veins
- ❑ Other_____

We know symptoms vary day to day. **Please indicate your levels when at their worst**.
Do your legs or ankles (0 none to 5 severe):
- ❑ Ache or hurt? 0.....1.....2....3....4.....5 Please describe_____
- ❑ Swell? 0.....1.....2....3....4.....5 Please describe_____
- ❑ Cramp? 0.... 1.....2....3....4.....5 Please describe_____
- ❑ Become restless? 0.....1... .2....3....4….5 Please describe_____
- ❑ Become tired? 0….1….2….3…4…5 Please describe_____
- ❑ Become heavy? 0.....1.....2....3....4....5 Please describe_____
- ❑ Itch? 0.....1.....2....3....4.....5 Please describe_____
- ❑ Other? 0.....1.....2....3....4.....5 Please describe_____

In your **FAMILY** is there a history of spider, varicose veins, deep venous thrombosis (DVT), pulmonary embolus (PE), stroke or blood clotting disorders? **Please state which**.

- Mother_____
- Father_____
- Grandparents_____
- Brother / Sister_____
- Aunt / Uncle_____
- Child_____

Family Medical History (i.e. diabetes, hypertension, cancer)

- Mother_____ □ Alive □ Deceased
- Father_____ □ Alive □ Deceased
- Grandparents_____ □ Alive □ Deceased
- Brother / Sister_____ □ Alive □ Deceased
- Aunt / Uncle_____ □ Alive □ Deceased
- Child_____ □ Alive □ Deceased

REVIEW OF YOUR SYSTEMS and HISTORY: Please check all that apply.

Venous: □ Ankle skin thickening/dryness □ Ankle discoloration □ Deep venous thrombosis (DVT) □ Superficial thrombophlebitis (phlebitis) □ Pulmonary embolus □ Rupture of a vein

Hematological: □ Clotting disorder □ Excessive bleeding □ Easy bruising □ Anemia
□ Transfusion, dates:_____

Constitution: □Weight loss □Weight gain □Night sweats □Fever

Cancer and date _____

Head: □ Migraines □ Migraines with aura □ Head trauma

Neck: □ Goiter □ Thyroid disease □ Carotid disease □Neck pain

Eyes: □ Decreased vision □ Blurred vision □ Double vision □ Glasses

Otolaryngeal: □ Deafness □ Ringing in ears □ Sinus drainage □ Nosebleeds □ Hoarseness

Cardiovascular: □ Heart disease □ Arrythmias □ PACEMAKER □ Mitral valve prolapse
□ Hypertension ☖PFO (patent foramen ovale) or ASD (atrial septal defect)
□ Chest pain/discomfort □ Atherosclerosis □ Swelling in feet or legs □ Lymphedema
□ TIAs, Stroke

Pulmonary: □ Cough □ Shortness of breath □ COPD □Wheezing □ Asthma

REVIEW OF YOUR SYSTEMS and HISTORY (cont.)

Gastrointestinal: □ Painful swallowing □ Nausea □ Vomiting □ Heartburn □ Diarrhea
□ Constipation □ Crohn's disease / IBS □ Hepatitis A, Hepatitis B, Hepatitis C

Genitourinary: □ Kidney or bladder disease □ Inability to urinate □ Painful urination
□ Prostate disease □ Erectile dysfunction □ Varicocele □ Infertility

Endocrine: □ Change of appetite □ Excessive thirst or urination □ Non-insulin dependent diabetes □ Insulin dependent diabetes □ Other_____

Immuno: □Immune disorder □Lupus □Raynaud's □HIV □Other_____

Musculo/Skeletal: □Weakness □Bone/joint deformity □Limited mobility
□Knee/hip surgery □Leg trauma

Neuro: □Seizures □Numbness/tingling in extremities □Incoordination □Head trauma
□Peripheral neuropathy

Skin: □Rash □Mottling □Sores □Change in color/size of moles

Psych: □Anxiety □Depression □Hallucinations □Insomnia □Alcoholism

Tobacco Usage: □ Currently, Every Day □ Currently, Some Days □ Former □ Never

Amount Used/Day:_____ Age Started:_____ Age Stopped:_____

Alcohol consumption: □ Currently, Every Day □ Currently, Some Days □ Former □ Never
Amount Used: _____ per □ day □ week

Type of Alcohol: □ Beer □ Wine □ Liquor □ Multiple

Drug Use**:**_____

PAST SURGICAL HISTORY (include year of procedure) _____

_____

_____

CURRENT MEDICAL INFORMATION

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

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

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

_____

_____

Preferred Pharmacy Name: _____ Phone Number: (____)_____

Approximate Location: (cross streets, city, etc.) _____

VASCULAR HISTORY

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

- □ No discomfort
- ❑ Leg elevation
- ❑ Exercise
- ❑ Flexion/extension of your feet
- ❑ Walking
- □ Support hose
- □ Wraps
- □ Cold packs
- □ Warm soaks

Pain medications:

- □ Aspirin
- □ Tylenol
- □ Ibuprofen
- □ Other meds: _____

Other methods: _____

What is the **earliest date** that you started taking any pain medications for **leg problems** and what was the outcome? _____

*What is the **earliest** date that you wore **medical support hose** for your legs?

_____

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

How long have you worn compression hose over the course of your life?
_____months _____years

Physician that prescribed compression hose: _____
Strength and type of hose prescribed: _____
What were the results? _____

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

Do your leg problems/symptoms negatively limit you in the following activities?

Daily activities at work	Y	N
Daily activities at home (housework, childcare, gardening, jobs/repairs)	Y	N
Social or leisure activities in which you are standing for long periods (parties, family gatherings, shopping, hobbies, etc.)	Y	N
Social or leisure activities in which you are sitting for long periods (cinema, theatre, traveling, etc.)	Y	N

Are there any other activities in which your leg problems limit you?

_____

Have your leg problems/symptoms limited the amount of time you have spent at work or other activities? Have you accomplished less than you would have liked to? Y N

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

Are you on your feet for long periods? _____In what capacity? _____

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

_____

Does walking/exercise relieve your discomfort, or make it worse? _____

As a result of your leg/vein problems, how have you felt?

	All of the time	Most of the time	Some of the time	None of the time
Have you felt concerned about the appearance of your legs?				
Have you been worried or stressed about bumping into things?				
Have you had trouble sleeping?				
Has the appearance of your legs affected your clothing choices?				

Have you been treated for your veins before?

By whom? _____ When? _____

By whom? _____ When? _____

What method?

- ❑ Cosmetic injections
- ❑ Stripping
- ❑ Ambulatory phlebectomy
- ❑ Ligation
- ❑ Ultrasound-guided injections
- □ Other _____
- □ Laser for spider vein
- □ Laser catheter ablation
- □ Radiofrequency closure

What have your results been? _____

_____

10.25.17/cr/db