

MORRISON VEIN INSTITUTE

Better Care. Better Results.

CONFIDENTIAL HEALTH & VASCULAR HISTORY: WOMEN

Name: _____ Date: _____

Primary Care Physician: _____ Phone: _____

Referring Doctor: _____ Phone: _____

And/or other information sources.....Please check one:

Magazines

- Phoenix Magazine
- Phx Home & Garden Magazine

TV

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

Radio

- KJZZ 91.5
- KTAR 92.3
- KBAQ 89.5
- KEZ 99.9

Newspaper

- AZ Republic

Miscellaneous

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

Years with varicose/spider veins _____

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

SYMPTOMS

Please check if you have:

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

We know symptoms vary day to day. **Please indicate your levels when they are at their worst.**

Do your legs or ankles (0 none to 5 severe):

- | | | |
|---|-----------------------|-----------------------|
| <input type="checkbox"/> Ache or hurt? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Swell? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Cramp? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Become restless? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Become tired? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Become heavy? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> Itch? | 0...1...2...3...4...5 | Please describe _____ |
| <input type="checkbox"/> 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)

- | | | |
|---|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Mother _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Father _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Grandparents _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Brother / Sister _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Aunt / Uncle _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> Deceased |
| <input type="checkbox"/> Child _____ | <input type="checkbox"/> Alive | <input type="checkbox"/> 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

Breasts: Lump. Last mammogram (date) _____ Abnormal mammogram Surgery Pain

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

REVIEW OF YOUR SYSTEMS and HISTORY (cont.)

Pulmonary: Cough Shortness of breath COPD Wheezing Asthma

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
 Hematuria Painful menstrual periods Pelvic congestion Pelvic pain Pelvic pain following intercourse Urinary frequency Labial or vaginal varicosities (now or during previous pregnancy)

Endocrine: Change of appetite Excessive thirst or urination Non-insulin dependent diabetes Insulin dependent diabetes other _____

Immuno: Immune disorder Lupus Raynaud's HIV other _____

Musc/Skeletal: Weakness Bone/joint deformity Limited mobility Knee/hip surgery
 Fibromyalgia Leg trauma

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

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

Psych: Anxiety Depression Hallucinations Insomnia

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.) _____

Are you pregnant or planning to be soon? _____ Are you currently breastfeeding? _____

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 | Cold packs |
| <input type="checkbox"/> Leg elevation | Pain medications |
| <input type="checkbox"/> Exercise | Aspirin |
| <input type="checkbox"/> Flexion/extension of your feet | Tylenol |
| <input type="checkbox"/> Walking | Ibuprofen |
| <input type="checkbox"/> Support hose | Other meds: _____ |
| <input type="checkbox"/> Wraps | Other methods: _____ |
| <input type="checkbox"/> Warm soaks | |

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 leg problems?

**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? _____

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? Yes___ No___

By whom? _____ When? _____

By whom? _____ When? _____

What method?

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

What have your results been? _____
