

MORRISON VEIN INSTITUTE

Better Care. Better Results.

CONFIDENTIAL HEALTH & VASCULAR HISTORY: MEN

PATIENT INFORMATION

Name: _____ Date: _____

Age: _____ Sex: _____ Years with varicose / spider veins? _____

HOW DID YOU HEAR ABOUT US?

Referring Doctor: _____

Or...Please check one:

Magazines

- AZ Foothills Magazine
- AZ Magazine
- Phoenix Magazine
- Phx Home & Garden Magazine

TV

- Channel 8 PBS
- Channel 12 NBC
- Channel 15 ABC

Radio

- KBAQ 89.5 FM
- KEZ 99.9 FM
- KJZZ 91.5 FM
- KTAR 92.3 FM
- KNIX 102.5 FM
- KOY 1230 AM

Newspapers

- AZ Republic
- Lovin' Life after 50

Miscellaneous

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

PRIMARY CARE INFORMATION

Primary Care Physician: _____ Phone Number: _____

SYMPTOMS

Please check if you have:

- | | |
|---|--|
| <input type="checkbox"/> Red spider veins | <input type="checkbox"/> Bulging veins |
| <input type="checkbox"/> Skin discoloration below your knee | <input type="checkbox"/> Flat bluish-green veins |
| <input type="checkbox"/> Purple veins | <input type="checkbox"/> Diagnosis of vein disease |
| <input type="checkbox"/> Purple vein network | <input type="checkbox"/> Leg ulcer |
| <input type="checkbox"/> Abdominal veins | <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
- Erectile difficulty/dysfunction
- 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): _____

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

What have your results been? _____

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

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BLEEDING HISTORY (Please check all that apply)

- Excessive bleeding Easy Bruising Aspirin Use Coumadin Use
 Other _____

SOCIAL HISTORY (Please check all that apply)

- Smoke _____ packs per day for _____ year
 Alcohol _____ use for _____ years
Occupation _____

REVIEW OF SYSTEMS (please check all that apply)

- Constitution: Weight Loss Weight Gain Night Sweats Fever
- Skin: Change in size/color of moles Rash Bruising
- Eyes: Decreased vision Double vision Blurred vision Glasses
- ENMT: Pain Deafness Discharge Ringing in ears
 Sinus Drainage Nose bleed Hoarseness
- Cardiac: Palpitations Chest pain discomfort Shortness of breath Fatigue
 Swelling in feet/legs Hypertension
- Gastro: Painful swallowing Nausea Vomiting Vomit blood
 Indigestion Diarrhea Constipation Tarry stools
 Yellow jaundice Bloody stools change in BMs
- Genito: Kidney/Bladder disease Decreased urine stream
 Unable to urinate Painful urination Blood in urine
- Musc/Skel: Weakness trauma Limited Motion Bone/joint deformity
- Neuro: Paralysis Weakness Seizure Fainting Headache Migraine
 Migraine with aura Numbness/tingling in extremities Incoordination
 Head trauma
- Psch: Anxiety Depression Hallucinations
- Endocrine: Change of appetite Excessive thirst/urination Goiter
- Hemato: Swollen lymph nodes Bleeding disorders
- Immuno: Immune disorders Immunosuppressant

Signature: _____ **Date:** _____