MORRISON VEIN INSTITUTE

Better Care. Better Results.

CONFIDENTIAL HEALTH & VASCULAR HISTORY: WOMEN

PATIENT INFORMATION

Name:______________________________ Date:__________

Age:____ Gender:_____ 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:
- ❑ Red spider veins
- ❑ Skin discoloration below knee
- ❑ Purple veins
- ❑ Ankle sores
- ❑ Purple vein network
- ❑ Abdominal veins
- ❑ Bulging veins
- ❑ Diagnosis of vein disease
- ❑ Flat bluish-green veins
- ❑ Vulva/labial veins
- ❑ Other______________

Do your legs or ankles:
- ❑ Ache or hurt? Please describe______________
- ❑ Swell? Please describe______________
- ❑ Cramp? Please describe______________
- ❑ Become restless? Please describe______________
- ❑ Become tired / heavy? Please describe______________
- ❑ Itch? Please describe______________
- ❑ 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
- ❑ Bladder disease
- ❑ Bleeding/blood disorder/blood transfusion_________(date)
- ❑ Cancer of___________
- ❑ Carotid disease
- ❑ 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
- ❑ Stroke
- ❑ Superficial thrombophlebitis
- ❑ Thyroid disease
- ❑ 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

PAST SURGICAL HISTORY (Include year of procedure)

____

____

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):

____

____

FEMALE HISTORY

Breast: □ Lump □ Pain □Nipple discharge □Infection □Trauma

□ Last mammogram (Date) ______________________

Gyn: □ Irregular periods □ Birth Control □ Hormone therapy □ Menopause
□ Last pelvic exam (date) ___________ □ Last period (date) ______________
□ Number of pregnancies__________ □ Number of stillbirths/miscarriages____

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? _______

VASCULAR HISTORY

Have you been treated for your veins before? _____________

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? ____

____

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:**_________________

MC 01.27.12/kdg