

# NEW PATIENT HISTORY FORM:

**NAME:** \_\_\_\_\_ (DoB: \_\_\_-\_\_\_-19\_\_\_) **DATE:** \_\_\_-\_\_\_-20\_\_\_  
 Who can we thank for referring you? \_\_\_\_\_

**REASON** for visit:  **SPIDER VEINS** for \_\_\_ years  **VARICOSE VEINS** for \_\_\_ years

1. Do you experience any of the following **SYMPTOMS?** **RIGHT LEG** **LEFT LEG**

IF YOU HAVE **NO**  
SYMPTOMS,  
PLEASE GO TO # 2.  
↓

- |                              |                          |                          |
|------------------------------|--------------------------|--------------------------|
| Aching or pain along a vein? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heaviness?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg tiredness or fatigue?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen ankles or feet?      | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg cramps?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless legs?               | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning?                     | <input type="checkbox"/> | <input type="checkbox"/> |

Other? \_\_\_\_\_

- ◆ How **LONG** have you experienced the above mentioned symptoms? \_\_\_\_\_
- ◆ How **OFTEN** do you experience these symptoms?  daily  weekly  monthly  
 other: \_\_\_\_\_

- ◆ Which of the following **IMPROVES** your symptoms?

	<u>HELPS</u>	<u>DOESN'T HELP</u>	<u>HAVEN'T TRIED</u>
Elevating legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rx Compression stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTC pain meds (advil, Tylenol, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

- ◆ Which of the following **WORSENS** your symptoms?

	<u>WORSE</u>	<u>NO CHANGE</u>	<u>N/A</u>
Prolonged standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

- ◆ How many **hours** a day do you spend **sitting or standing?** \_\_\_\_\_

2. Have your legs gotten significantly **worse** in the last few **months?**  no  yes
3. Have you had leg vein **TREATMENT in the PAST?**  no  yes → please answer the following:  
 When? \_\_\_\_\_ By whom? \_\_\_\_\_  
 Was an ultrasound done of your legs before treatment?  no  yes ?  
 What treatment(s) were done?  injections  laser  stripping  can't remember  
 Did you wear graduated compression stockings after treatment?  no  yes  
 What was your result? \_\_\_\_\_

4. Have you had any **MAJOR INJURIES** to either leg?  no  yes: \_\_\_\_\_  
 Have your legs ever been in a cast?  no  yes →  right  left

5. **FEMALES ONLY:**

- ◆ **Obstetric history:** Number of pregnancies: \_\_\_ Number of children: \_\_\_ (please list ages: \_\_\_\_\_)  
 Number of miscarriages: \_\_\_ Are you now (or in the next 6 months) trying to conceive?  no  yes
- ◆ Do you use **birth control?**  no  yes → method:  the pill  other: \_\_\_\_\_
- ◆ Are you **menopausal:**  no  yes → are you currently using **estrogen** replacement?  no  yes

Date of last pap smear: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

Reviewed: \_\_\_\_\_  
 Monica Brar, M.D.

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**6. PERSONAL MEDICAL HISTORY:** Please check all that apply to you:

Patient Name: \_\_\_\_\_  
 Primary Care MD: \_\_\_\_\_

**CARDIOVASCULAR:**

- normal
- high blood pressure
- high cholesterol
- heart disease
- mitral valve prolapse
- heart attack history
- \_\_\_\_\_

**ENDOCRINE:**

- normal
- diabetes, type \_\_\_\_\_
- thyroid problems
- \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC:**

- normal
- coagulopathy** (clotting disorder making blood too thick and prone to clotting): Type: \_\_\_\_\_
- deep vein thrombosis** (aka: DVT, or a blood clot in a deep vein in the leg): When? \_\_\_\_\_ Which leg?  right  left  
 Treatment given? \_\_\_\_\_ How long were you treated? \_\_\_\_\_
- pulmonary embolism** (aka: PE, or a clot that has traveled to the lungs): When? \_\_\_\_\_ How long were you treated? \_\_\_\_\_
- phlebitis** (inflammation of a varicose vein with pain, redness, hard lump): When? \_\_\_\_\_ Which leg?  right  left
- anemia
- \_\_\_\_\_

◆ **PERSONAL CANCER HISTORY?**  no  yes: (when and type): \_\_\_\_\_

◆ **OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:** \_\_\_\_\_

**NEUROLOGIC:**

- normal
- migraines
- stroke
- seizures
- \_\_\_\_\_

**PSYCHIATRIC:**

- normal
- anxiety/panic attacks
- depression
- \_\_\_\_\_

**RESPIRATORY:**

- normal
- asthma
- \_\_\_\_\_

**RHEUMATOLOGIC/  
MUSCULOSKELETAL:**

- normal
- arthritis
- lupus
- fibromyalgia
- osteopenia/porosis
- muscular problems
- \_\_\_\_\_

**GASTROINTESTINAL:**

- normal
- irritable bowel syndrome
- GERD (reflux/heartburn)
- colitis
- ulcers
- liver disease
- \_\_\_\_\_

**GYN / UROLOGIC:**

- normal
- menstrual problems
- breast problems
- bladder problems
- kidney problems
- \_\_\_\_\_

**7. PERSONAL SURGICAL HISTORY:** Please list all past surgeries with approximate date:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**8. SOCIAL HISTORY:**  married  single  divorced  widow or widower

- ◆ **Occupation:** \_\_\_\_\_ for \_\_\_\_\_ years
- ◆ **Cigarette smoking:**  no  yes: \_\_\_\_\_ packs per day for \_\_\_\_\_ years
- ◆ **Alcohol consumption:**  never  <=1 drink/month  \_\_\_ drinks every \_\_\_ day(s)
- ◆ **Recreational drug use:**  no  yes: \_\_\_\_\_
- ◆ **Exercise:**  not at all  1 to 3 times/week  4 to 6 times/week  daily  
 What type of exercise do you do? \_\_\_\_\_

**9. DRUG ALLERGIES:**  none  latex  yes, allergies → please list below with type of allergic reaction:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**10. CURRENT MEDICATIONS:** Please list below with dosages if possible:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**11. FAMILY HISTORY:**  unknown List your **siblings** also please:

	Alive	Deceased	Age	spider veins?	Varicose veins?	Clot in leg or lungs?	Clotting disorder?
◆ Mother:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ Father:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reviewed:  
 \_\_\_\_\_  
 Monica Brar, M.D.