NEW PATIENT HISTORY FORM:

EAST BAY VEIN CENTER ◈ 600 San Ramon Valley Blvd, Suite # 102, Danville, CA, 94526 ◈ phone 925.838.4900 ◈ fax 925.838.4920

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**?

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

	RIGHT LEG	LEFT LEG
Aching or pain along a vein?	☐	☐
Heaviness?	☐	☐
Leg tiredness or fatigue?	☐	☐
Swollen ankles or feet?	☐	☐
Leg cramps?	☐	☐
Restless legs?	☐	☐
Itching?	☐	☐
Burning?	☐	☐

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?

	HELPS	DOESN'T HELP	HAVEN'T TRIED
Elevating legs	☐	☐	☐
Rx Compression stockings	☐	☐	☐
Exercise	☐	☐	☐
OTC pain meds (advil, Tylenol, etc)	☐	☐	☐

Other: _____

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

	WORSE	NO CHANGE	N/A
Prolonged standing	☐	☐	☐
Prolonged sitting	☐	☐	☐
Heat	☐	☐	☐
High heels	☐	☐	☐
Menstruation	☐	☐	☐

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.

Patient Name: _____
Primary Care MD: _____

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

CARDIOVASCULAR:
- ☐ normal
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ heart disease
- ☐ mitral valve prolapse
- ☐ heart attack history
- ☐ _____

ENDOCRINE:
- ☐ normal
- ☐ diabetes, type ____
- ☐ thyroid problems
- ☐ _____

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
- ☐ _____

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:** _____

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:	☐	☐	____	☐	☐	☐	☐
◆ Father:	☐	☐	____	☐	☐	☐	☐
◆ _____	☐	☐	____	☐	☐	☐	☐
◆ _____	☐	☐	____	☐	☐	☐	☐
◆ _____	☐	☐	____	☐	☐	☐	☐

Reviewed:
_____
Monica Brar, M.D.