LA VEIN CENTER
Larisse K. Lee, MD
Vascular and Endovascular Surgery

PATIENT HEALTH HISTORY

Patient Name ______________________________

Date of Birth ______________________ Age ______________________

CHIEF COMPLAINT

What is the reason for your visit? ______________________

When did you first notice this problem? ______________________

Has it improved/gotten worse/stayed the same? ______________________

What would you like to achieve from your visit? ______________________

SYMPTOMS

Please check the symptoms you have experienced:

Leg pain	☐ R	☐ L	
Leg/Ankle swelling	☐ R	☐ L	
Leg fatigue	☐ R	☐ L	
Leg heaviness	☐ R	☐ L	
Leg itching	☐ R	☐ L	
Leg ulcers (sores)	☐ R	☐ L	
Leg bleeding	☐ R	☐ L	
Leg cramping	☐ R	☐ L	
Restless legs	☐ R	☐ L	
Skin discoloration	☐ R	☐ L	Where ______________________
Phlebitis	☐ R	☐ L	Where ______________________

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WHAT MAKES YOUR SYMPTOMS WORSE:

Prolonged standing ______________________

Prolonged sitting ______________________

Walking ______________________

Working ______________ Please describe ______________

At end of day ______________________

Other ______________________

WHAT MAKES YOUR SYMPTOMS BETTER:

Leg elevation ______________________

Compression stockings ______________________

Medication ______________ Name ______________

Other ______________________

OCCUPATION AND LIFESYTLE

What is your occupation? ______________________

Does your occupation require prolonged standing or sitting? ______________

Do your symptoms interfere with your lifestyle or work? ______________

In what way? ______________________

COMPRESSION STOCKING USE

Have you worn compression stockings? ______________________

When did you first try them? ______________________

Are you still wearing them? ______________________

Have they helped? ______________________

Were they prescribed or over the counter ______________________

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PAST MEDICAL HISTORY

Please list all your Past Medical Problems (ie, hypertension, high cholesterol, diabetes, etc)

DVT ☐ Y ☐ N

Easy bruising ☐ Y ☐ N

Migraines ☐ Y ☐ N

Other ____

____

Are you on Dialysis? ☐ Y ☐ N

What days do you get dialysis?______________________________

What is the name of your dialysis center? ______________ phone number: __________

What is the name of your kidney doctor?______________ phone number: __________

PAST SURGICAL HISTORY

Please list all your Past Surgeries

Vein stripping ☐ Y ☐ N

Vein ablation ☐ Y ☐ N

Phlebectomy ☐ Y ☐ N

Sclerotherapy ☐ Y ☐ N

Other ____

____

SOCIAL HISTORY

Do you smoke?________ How many cigarettes a day?________ When did you start/quit?______

Do you drink alcohol?______________ How many drinks a week?____________________

Do you use recreational drugs?______________ Please list____________________

ALLERGIES

Do you have any allergies? (Includes medication, foods, latex, tape, iodine, lidocaine)

____

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MEDICATION

Please list your medications below:

Name ______________________________ Dosage ______________________________

Asprin ☐ Y ☐ N

Plavix ☐ Y ☐ N

Lovenox ☐ Y ☐ N

Coumadin ☐ Y ☐ N

List all others: ______________________________

FAMILY HISTORY

Please list health conditions that run in your family.

Varicose or spider veins ☐ Y ☐ N Who? ______________________________

DVT ☐ Y ☐ N Who? ______________________________

Blood clotting disorder ☐ Y ☐ N Who? ______________________________

Other ______________________________

REVIEW OF SYSTEMS

Please check if you have experienced any of the following:

CONSTITUTIONAL

☐ Fatigue ☐ Weight Gain ☐ Weight Loss ☐ Other ______________________________

HEAD

☐ Watery Eyes ☐ Sore Throat ☐ Nasal Drip ☐ Other ______________________________

RESPIRATORY

☐ Shortness of Breath ☐ Cough ☐ Phlegm Production ☐ Wheezing

Other ______________________________

CARDIOVASCULAR

☐ Chest Pain ☐ Heart Palpitations ☐ Heart Failure ☐ Heart Murmur

☐ Other ______________________________

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GASTROINTESTINAL

☐ Abdominal Pain ☐ Nausea ☐ Blood in Stool ☐ Diarrhea ☐ Constipation

☐ Other ______

GENITOURINARY

☐ Burning with Urination ☐ Blood in Urine ☐ Frequent Urination ☐ Incontinence

☐ Other ______

MUSCULOSKELETAL

☐ Muscle Pain (where?) ______

☐ Joint Pain (where?) ______ ☐ Fibromyalgia

SKIN

☐ Rash (where?) ______

☐ Itch (where?) ______

☐ Discoloration (where?) ______

NEUROLOGIC

☐ Transient weakness in arm or leg ☐ Change in Consciousness ☐ Seizure

☐ Other

INFECTIOUS DISEASE

☐ HIV+ ☐ Hepatitis B/C ☐ Recent Fever

FOR WOMEN

Are you currently pregnant? ______

How many pregnancies have you had? ______

Do you have prominent veins in your pelvis? ______

Do you have pelvic pain? ______

Is it worse with standing? ______

Is it worse with menstruation? ______

Do you have pain with intercourse? ______

Please list any other information you would like for us to know regarding your health:

______

______

______

______