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Healthy Never Looked So Good

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Occupation: _____ Height: _____ Weight: _____lbs.

Who can we thank for referring you to our practice? _____

What is your main reason for today's visit? ☐ Spider Veins ☐ Varicose Veins

Please mark neatly symptoms you present with:

- ☐ Tired Heavy Legs
- ☐ Burning Sensation
- ☐ Ankle / Leg Swelling
- ☐ Stinging Sensation
- ☐ Aching / Throbbing
- ☐ Red Warm Areas
- ☐ Restless Legs
- ☐ Leg Pain
- ☐ Cramping
- ☐ Itching
- ☐ Tenderness
- ☐ Open Sore / Ulcer

Have symptoms progressed or gotten worse in recent weeks / months? ☐ YES ☐ NO

When are your symptoms more intense?

- ☐ After prolonged sitting
- ☐ After prolonged standing
- ☐ When walking
- ☐ During the night
- ☐ During summer months
- ☐ After warm baths or showers
- ☐ Menstrual cycle

Do you feel symptoms are improved by:

- ☐ Rest and Elevation
- ☐ Walking Exercises

Does your day consist of prolonged periods of standing at home or work? ☐ YES ☐ NO

Do you need to rest and elevate your legs throughout the day? ☐ YES ☐ NO

Do you need to rest and elevate your legs at the end of the day? ☐ YES ☐ NO

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week? _____

What type of exercise do you do?

- ☐ Walking,
- ☐ Running
- ☐ Cardio
- ☐ Weights
- ☐ Other (Please specify) _____

Have you ever worn prescription grade compression stockings? ☐ YES ☐ NO

When did you begin wearing prescription grade compressions stockings? _____

IF YES, please check off one of the following:

- ☐ Knee High
- ☐ Thigh High
- ☐ Pantyhose

Compression Stocking Strength:

- ☐ <20mmHG
- ☐ 20-30mmHg
- ☐ 30-40mmHg

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Any improvements wearing stockings? ☐ YES ☐ NO

Have you taken any medications whether prescription of over-the-counter to help alleviate your symptoms?

☐ YES

☐ NO

IF YES, please specify:

DRUG NAME	STRENGTH	FREQUENCY

PATIENT MEDICAL HISTORY

ALLERGIES TO MEDICATIONS AND FOODS:

1. _____
2. _____
3. _____
4. _____

CURRENT PRESCRIPTION MEDICATIONS:

1. _____
2. _____
3. _____
4. _____

CURRENT NON-PRESCRIPTION MEDICATIONS (including over-the-counter medications, vitamins and herbal remedies):

1. _____
2. _____
3. _____
4. _____

Are you currently on any blood thinning medications? ☐ YES ☐ NO

Tobacco Use? ☐ YES ☐ NO IF YES, _____ per day Number of years _____

Is there a family history of blood clots? ☐ YES ☐ NO

Please check if you have ever been diagnosed or treated for the following:

☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis

☐ Diabetes ☐ High Cholesterol ☐ Phlebitis/Blood Clots (Superficial or Deep)

☐ Arthritis ☐ Hypothyroid ☐ Lung Disease/COPD/Asthma

☐ Pulmonary Embolus ☐ HIV/AIDS ☐ Other_____

Any past medical surgeries and/or hospitalizations? ☐ YES ☐ NO

IF YES, please specify: _____

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FEMALES ONLY: Are you currently pregnant or trying to become pregnant? ☐ YES ☐ NO

Total number of pregnancies: _____ Total number of miscarriages: _____

Currently breast feeding: ☐ YES ☐ NO

Currently on hormone therapy: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____

PHYSICIAN ADDRESS / PRACTICE: _____

PHYSICIAN PHONE NUMBER: _____

PHARMACY YOU USE (Please include location):_____

FOR PHYSCIAN'S USE ONLY BEYOND THIS POINT

CEAP Clinical Score	Description	Physician Assessment
C0	No visible or palpable varicose veins	
C1	Telangectasia	
C2A	Varicose veins without any sypmtoms	
C2S	Varicose veins with sypmtoms	
C3	Swollen ankle due to varicose veins	
C4	Skin damage due to varicose veins	
C5	Healed venous ulcer	
C6	Venous leg ulcer	