

Comprehensive Vein Clinic

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VASCULAR PATIENT QUESTIONNAIRE

Date: ____/____/____

Patient Name: _____ D.O.B ____/____/____ Age: _____

Contact Number: ____-____-____ Cell ____-____-____ Insurance Company: _____

Referring Physician: _____ (or) Self Referral Yes () No ()

How did you hear about us? (News paper, Magazine, your doctor, friend, etc.) _____

Chief Complaint: (How can we help you?) _____

Current Medical Conditions: () Diabetes () Heart problems () high blood Pressure () Bleeding Problem () Stroke

() Poor Circulation () Prior Blood Clots in Legs or Lungs () Thyroid Problems

() Other: _____

Your Symptoms: (Mark all that Apply)

When did your symptoms begin ? _____

Which leg is involved? () Right Leg () Left Leg () Both () Equal (If not which is worse?) () Right () Left

() Aches () Heavy/fullness () Cramping () Pain () Muscle fatigue () Burning () Swelling () easy Bruise () Itch

() Bleed/hemorrhage () Pelvic symptoms () Leg restlessness () Phlebitis () Significant or Recurring

() Ulceration: () Healed () Non-healed (How long) () Other: _____

() I am able to walk (one) mile without symptoms

() Symptoms interfere with my activities of daily living: On a scale of 1 – 10, 1 = least pain, 10 = worst pain, What would you rate your pain at it's worst? **1 2 3 4 5 6 7 8 9 10**

What makes it worse?

() Standing () Sitting () Walking / Exercise () Heat () Worsening of symptoms with pregnancy () Pre-Menstrual () Night

() Other: _____

What makes it better?

() Elevating Legs () Better in AM () Exercise () Lying down () Support stockings () Nothing

What conservative therapy, are you / have you tried?:

() Elevation () Exercise () Elastic compression stockings: When first started? _____

() Medications: _____ (Advil / Aspirin / Aleve / Anti-inflammatory / Tylenol / Motrin / Naprosyn)

Other: _____

Previously Invasive treatment: **Surgery**.....

() Stripping () Right Leg () Left Leg Date: ____/____/____ Location: _____

() Ligation () Right Leg () Left Leg Date: ____/____/____ Location: _____

() Angioplasty () Right Leg () Left Leg () Iliac () Femoral () Popliteal Date: ____/____/____ Location: _____

() Stent placement () Right Leg () Left Leg () Iliac () Femoral () Popliteal Date: ____/____/____ Location: _____

() Vascular bypass () Right Leg () Left Leg () Iliac () Femoral () Popliteal Date: ____/____/____ Location: _____

Injections: () Right Leg () Left Leg Complications: _____ Date: _____

Laser: () Right Leg () Left Leg Complications: _____ Date: _____

Medical Allergies: (Hives, Rash, Breathing problem, Shock)

Current Medications: () Coumadin () Aspirin () Plavix () Pletal

Patient Name: _____

Medical History Continued: (If Yes, please explain)

- () Prior problems with local anesthesia _____
- () Prior problems with general anesthesia _____
- () Prior problems with contrast dye (ie: IVP, CT scan, Cardiac cath, Etc.) _____

Past surgeries:

Social History:

Occupation _____ () Retired () Disabled / Martial status: () Single () Married () Separated () Divorced () Widow () Lives alone
Tobacco use: () Yes () No _____ Packs/day () Currently quit Alcohol use: () Daily () Social () Illicit Drugs use

Family History:

Have any of the family members below had any of the following? (If yes, please indicate)

Heart problems, Diabetes, Stroke, Lung or breathing problems, High blood pressure, Cancer, or any other signify cant illness:

Mother: _____ Sisters: _____

Father: _____ Brothers: _____

Review of Symptoms: (Please circle any item that apply to you)

- General Health:**..... Poor Fair Good Excellent
- Skin:**..... Warts Moles Cancer Easy Bruising
- Eyes:**..... Glasses Night blindness Double vision Loss of vision in either eye
- Ears:**..... Ringing Hearing Loss
- Nose and Throat:**..... Nose bleeds Hoarseness Swallowing difficulty
- Respiratory:**..... Pneumonia Asthma Coughing up blood Shortness of breath with activity
- Heart:**..... Chest pain Heart attack Ankle swelling Shortness of breath when lying down
- Digestive:**..... Ulcers Jaundice Vomiting blood Rectal bleeding Unexplained weight loss
- Genitourinary:**..... Difficulty urinating Urinary incontinence Numbness in region of genitals/rectum
Men: Difficulty with erection
- Musculoskeletal:**..... Sore muscles/joints Swelling joints Painful joints Leg Cramps Fractures
- Neuropsychiatric:**..... Headache Fainting Seizures Insomnia Dizziness Depression Hearing voices
Speech difficulty Weakness of arms/legs Paranoia Numbness of arms / legs / face
- Endocrine:**..... Heat or cold intolerance Excess fatigue Breast discharge
Women: Unexplained disruption of periods Post menopause
- Other:**..... _____

If you are a candidate for treatment, when would you like to have it done? _____

If your insurance denies coverage for treatment which they occasionally will, are you interested in pursuing therapy regardless?

“THANK YOU FOR CHOOSING OUR OFFICE AS WE APPRECIATE YOUR CONFIDENCE IN OUR MEDICAL EXPERTISE”

Patient Signature Date

Physician Signature Date
Andrew Dobradin, MD, Ph. D, FACS