

Name: _____
 Date: _____ Date of Birth: _____ Age: _____



Patient History

Symptoms: (Please check if yes)	R	L		Check if you've had any of the following:	
Aching / pain in legs	<input type="checkbox"/>	<input type="checkbox"/>		Heart disease	<input type="checkbox"/>
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>		Peripheral arterial disease	<input type="checkbox"/>
Tiredness / fatigue	<input type="checkbox"/>	<input type="checkbox"/>		HIV	<input type="checkbox"/>
Itching / burning / warmth	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>
Leg cramping	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>
Leg restlessness	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>		Leg trauma / surgery	<input type="checkbox"/>
Do your symptoms interfere with your sleep?			<input type="checkbox"/>	Asthma/COPD	<input type="checkbox"/>
Are your symptoms worse later in the day?			<input type="checkbox"/>	Major surgery / hospitalizations:	<input type="checkbox"/>
Are your symptoms worse with or after activity?			<input type="checkbox"/>	_____	
Do your symptoms keep you from doing anything?			<input type="checkbox"/>	_____	
				Do you have an Advanced Directive?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any Peripheral Arterial Disease (PAD) Symptoms? Check all that apply:

- Was diagnosed with PAD in past
- Have/had cramping leg pain that worsens with walking, forcing me to stop walking
- Feet/toes become pale and painful with exercise or when elevating them
- Have/had ulcers on feet or toes

Conservative Measures Used Currently or Previously: (please check those measures that you have tried)

- Exercise Weight loss **Have you worn compression stockings or leg wraps?** Yes No
- Leg elevation Job change If yes, what was the strength of the stockings? _____ mmHg
- Pain medication If yes, how long did you wear compression stockings? _____ months _____ years

Restless Legs Syndrome: (Please check box if yes)

- Do you find the need to move your leg(s) to relieve an uncomfortable feeling?
- Do(es) your leg(s) feel better when moving it (them) or walking?
- Are your leg symptoms worse when sitting or resting, without elevating your leg(s)?
- Are your leg symptoms worse later in the day or night?

Please check below if you have, or have had, any of the following:

- | | |
|---|--|
| <input type="checkbox"/> A prior evaluation for your veins: _____ (yr) | <input type="checkbox"/> A family history of vein disease |
| <input type="checkbox"/> Previous vein surgery or laser treatments: _____ (yr) R L | <input type="checkbox"/> A family history of leg ulceration |
| <input type="checkbox"/> Previous vein injections: _____ (yr) R L | <input type="checkbox"/> A family history of blood clots |
| <input type="checkbox"/> Bleeding from a vein: _____ (yr) R L | <input type="checkbox"/> A family history of a clotting disorder |
| <input type="checkbox"/> A leg ulceration: _____ (yr) R L | |
| <input type="checkbox"/> Superficial thrombophlebitis or an inflammation of a vein: _____ (yr) R L _____ (Location) | |
| <input type="checkbox"/> Any type of blood clot: _____ (yr) R L _____ (Location) | |
| <input type="checkbox"/> Any type of clotting disorder: _____ (Diagnosis) | |
| <input type="checkbox"/> Migraines with aura | |
| <input type="checkbox"/> Diagnosed with a PFO (patent foramen ovale) | |

Women Only: (Please check box if yes)

- Are you pregnant or considering a pregnancy sometime in the future?
- Are you breast-feeding? Are your legs more painful associated with menstruation?
- Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy?
- Number of Pregnancies: _____ Deliveries: _____ Miscarriages: _____ Children's ages: _____

Provider reviewed with patient: _____ **Date:** _____

Today's Date: _____ Your Appointment Time: _____ a.m. / p.m. Clinic Location: _____

Date of Birth: _____

Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to State
Preferred Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to State	
Weight: _____ lbs. and height: _____ ft. _____ in	

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?

Date of Last Flu Shot ____/____/____ No/Refused Decline for Medical Reason → Allergy Other Medical Reason
(Month/Year)

Social History:

Tobacco Use History Never smoked or used tobacco Former smoker but quit on _____ (approx. date)
 Current Smoker → Started _____ (approx. date) Amount of cigarettes: _____ per day
 Use tobacco in other forms → _____ Amount: _____ per day

Alcohol Use History: Did you have a drink containing alcohol in the past year? NO YES

If Yes: → How often? monthly or less _____ drinks per month _____ drinks per week _____ drinks per day

How often >6 drinks on one occasion in past year? Never Less than monthly Monthly Weekly Daily

Allergies and Your Allergic Response: or No Known Allergies

_____ Rash Nausea/Vomiting Diarrhea Shortness of Breath Anaphylaxis Other: _____
 _____ Rash Nausea/Vomiting Diarrhea Shortness of Breath Anaphylaxis Other: _____
 _____ Rash Nausea/Vomiting Diarrhea Shortness of Breath Anaphylaxis Other: _____

Current Medications: Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements

None

#	Medication Name	Dose	Frequency	Route
1				<input type="checkbox"/> Oral <input type="checkbox"/>
2				<input type="checkbox"/> Oral <input type="checkbox"/>
3				<input type="checkbox"/> Oral <input type="checkbox"/>
4				<input type="checkbox"/> Oral <input type="checkbox"/>
5				<input type="checkbox"/> Oral <input type="checkbox"/>
6				<input type="checkbox"/> Oral <input type="checkbox"/>
7				<input type="checkbox"/> Oral <input type="checkbox"/>

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Blood Pressure: _____ / _____ R L MRN: _____

Staff Signature: _____ Date: _____

Patient Education from Healthwise: Tobacco Cessation <24 months Hypertension >140/90 or pre-hypertension 120/80 to 139/89

Provider Signature: _____ Date: _____

Diagnosis Code(s) from Encounter Form: (1) Primary: _____ Others: _____