SCOTTSDALE VEIN CENTER

Patient Medical History

Patient Name _____Date_____

DOB: ___/___/_____

What Would You Most Like to Correct About Your Legs (or other region(s) to be treated)?

_____

_____

_____

_____

_____

Years With Varicose/Spider Veins: _____

Vein / Skin Conditions

- ☐ None
- ☐ Small Red "Spider" Veins
- ☐ Diagnosed With Vein Disease
- ☐ Purple Veins
- ☐ Skin Discoloration
- ☐ Purple Vein Networks
- ☐ Other: (Please Describe)
- ☐ Flat, Blue-green Veins
- ☐ Abdominal Veins
- ☐ Bulging Veins
- ☐ Vaginal Veins
- ☐ Ankle Sores

_____

_____

_____

_____

Leg and Ankle Problems (Please Explain Any Yes Answers)

Aches and Pains: ☐ Yes ☐ No

Swelling: ☐ Yes ☐ No

Cramps: ☐ Yes ☐ No

Restlessness: ☐ Yes ☐ No

Tired / Heavy: ☐ Yes ☐ No

Itching: ☐ Yes ☐ No

Other ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

SCOTTSDALE VEIN CENTER

Patient Medical History

Do You Have a Family History of Spider / Varicose Veins?

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Grandmother/Grandfather
- ☐ Sister/Brother
- ☐ Son/Daughter
- ☐ Aunt/Uncle
- ☐ Other _____

Do You Have a Family History of Deep Thrombosis, Heart Disease, Stroke, Clotting Disorders?

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Grandmother/Grandfather
- ☐ Sister/Brother
- ☐ Son/Daughter
- ☐ Aunt/Uncle
- ☐ Other _____

Please check any conditions you have or have had in the past, and give the dates for each. If none, please check the box labeled 'None'.

Condition	Dates	Condition	Dates
☐ None			
☐ Anemia		☐ HIV / AIDS	
☐ Ankle Skin Changes		☐ Hypertension	
☐ Atherosclerosis		☐ Kidney Disease	
☐ Bleeding / Blood Disorder		☐ Leg Ulcers	
☐ Chest Pain or Discomfort		☐ Liver Disease	
☐ Constipation		☐ Lupus	
☐ Crohn's Disease / IBS		☐ Migraine Headaches	
☐ Deep Vein Thrombosis / Clot		☐ Mitral Valve Prolapse	
☐ Diabetes (Insulin Dependent)		☐ Pulmonary Embolus	
☐ Diabetes (Non-Insulin Dependent)		☐ Rupture of a Vein	
		☐ Smoker	
☐ Easy Bruising		☐ Stroke	
☐ Heart Disease		☐ Superficial Thrombophlebitis	
☐ Hepatitis A B C		☐ Trauma To Legs	
☐ Obesity		☐ Surgeries (Date/type)	

☐ Other: _____

_____

_____

Your Current Medical Situation

Do you have allergies? ☐ Yes ☐ No
If Yes, please describe

_____

Do you have any current illnesses? ☐ Yes ☐ No
If Yes, please describe

Are you currently taking any Prescription Medications, Vitamins or Herbal Supplements? ☐ Yes ☐ No If Yes, please describe (Please use back of sheet or last page of this information sheet for additional space.)

SCOTTSDALE VEIN CENTER

Patient Medical History

Women Only:

Are you now, or are you planning to be pregnant?
☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No

Do you have discomfort around your menses? ☐ Yes ☐ No

How many pregnancies have you had? _____
(Please include miscarriage(s) _____)

List of prescriptions, vitamins, &/or herbal supplements:

_____

_____

_____

_____

What Methods Have You Used To Relieve Leg Discomfort?

☐ No Discomfort
☐ Leg Elevation
☐ Flexion / Extension Of Feet
☐ Compression Stockings/Support Hose
☐ Warm Soaks
☐ Aspirin
☐ Ibuprofen
☐ Other: (Please describe)

☐ Tylenol
☐ Exercise
☐ Walking
☐ Wraps
☐ Cold Packs

Are you on your feet for long periods of time? ☐ Yes ☐ No
If Yes, in what capacity? _____
Does walking ☐ increase or ☐ decrease discomfort?
Have you had any Previous Vein Treatments? ☐ Yes ☐ No

Treatment Date: _____
Treatment Provider: _____
Treatment Date2: _____
Treatment Provider2: _____
Treatment Date3: _____
Treatment Provider3: _____

If Yes, what Treatment Methods have been used?

☐ Ambulatory phlebectomy
☐ Visual/ultrasound-guided sclerotherapy
☐ Laser endovenous ablation
☐ Bilateral ambulatory phlebectomy
☐ Right ambulatory phlebectomy
☐ Bilateral laser ablation
☐ Right laser ablation
☐ Bilateral radio frequency ablation
☐ Right radio frequency ablation

☐ Ligation and/or stripping
☐ Radio frequency ablation
☐ Laser ablation
☐ Left ambulatory phlebectomy
☐ Avulsion phlebectomy
☐ Left laser ablation
☐ Laser for spider veins
☐ Left radio frequency ablation
☐ Radio-frequency endovenous ablation

☐ Other (explain):

What were the results of the(se) treatment(s)?

If any procedure is cancelled in less than 24 hours from its scheduled time and date, Patient agrees to a $100.00 service charge.

Signature: _____ Date _____