Gilvydis Vein Clinic

Examination Questionnaire

Patient Last Name_____Patient First Name_____Date____/_____/____

Date of Birth: ____/____/____ Age: _____ Sex: M / F # of pregnancies: ____ Height _____ Weight _____

Primary Physician:_____ Referred by:_____

OB/GYN: _____ Dermatologist: _____

General Medical History
List past and present medical illnesses you have been treated for and year diagnosed:

_____

_____

List any surgeries and year performed:_____

_____

Please list any allergies and reaction you may have: _____

Are you allergic to: Latex YES NO _____Reaction
Iodine YES NO _____Reaction
Adhesive YES NO _____Reaction
Lidocaine YES NO _____Reaction

Medications; Prescription/Non-Prescription: **Include dose and how often you take the medication**:

_____

_____

_____

Do you smoke? Yes No If Yes, how many packs per day_____

Vein History

Are the problems you are having with your legs interfering with your daily lifestyle? (Please circle all that apply)
(Right leg only/Left leg only/Both legs)

Walking *Work Exercise Stairs Kneeling Social Activities Sleeping

Other: _____

***If Symptoms interfere with WORK, by how much?** Not at all, Mildly, Moderately, Severely, Unable to work

Do any of the following cause discomfort for you? (Please circle all that apply)

Prolonged Standing/Sitting Hot weather/Hot Baths Menstrual Cycle Pregnancy Walking

Do any of the following temporarily relieve your symptoms? (Please circle all that apply)

Elevating Walking Compression Stockings Medication Warm/cold packs Resting

Do you experience any of the following symptoms? (Occasional or Frequent - Please circle all that apply)

Leg Swelling	Right	Left	Ulcer	Right	Left
Tiredness/Fatigue	Right	Left	Rash on Leg	Right	Left
Burning	Right	Left	Skin Color Change	Right	Left
Itching	Right	Left	Bulging Vein	Right	Left
Cramps	Right	Left	Bleeding	Right	Left
Restless Leg	Right	Left	Aching or Pain	Right	Left
Fullness	Right	Left	Throbbing	Right	Left

On a scale of 1-10, (with 10 being the worst), where would you rate your LEG pain/discomfort? (Circle one)

1 2 3 4 5 6 7 8 9 10

Quality of pain (circle all that apply): **Sharp Dull Pulling Achy Throbbing Tightness**

Have you had any treatment on your varicose veins/spider veins? Yes No

***If Yes, please explain type and leg:_____

Family History

	Venous Ulcer	Varicose Veins	DVT	PE	Phlebitis	PVD	Leg Swelling	Heart Murmur
Yourself	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐
Pat. Grandparent	☐	☐	☐	☐	☐	☐	☐	☐
Mat. Grandparent	☐	☐	☐	☐	☐	☐	☐	☐

☐ **No family history of varicose vein disease**

Please check either "Yes" or "No" if you are currently being treated for these medical conditions.

Cardiovascular	**Yes**	**No**
Heart Attack	_____	_____
ASD/VSD/PFO	_____	_____
Heart Murmur	_____	_____
Blood Clots	_____	_____
Atrial Fibrillation	_____	_____
Congestive Heart Failure	_____	_____

Peripheral Vascular	**Yes**	**No**
Peripheral Artery Disease	_____	_____
Diabetes	_____	_____
Respiratory		
Shortness of Breath	_____	_____
Sleep Apnea	_____	_____
CPAP/BiPap Use	_____	_____
COPD	_____	_____

1. Have you had the flu immunization? **Yes** **No** **Declined** (PCP Offered)

ANSWER THE FOLLOW IF OVER 65 YEARS OLD:

1. Have you had the pneumonia vaccine? **Yes** **No**

2. Do you have advance directives (Healthcare living will/ power of attorney)? **Yes** **No** **Declined to respond**

If yes, Name of Power of Attorney: _____

BELOW TO BE COMPLETED BY OFFICE STAFF

BP _____/_____ Pulse _____

Right leg	**Left leg**
Ankle_____	Ankle_____
Calf_____	Calf_____
Thigh_____	Thigh_____
Leg length_____	Leg length_____
Calf length_____	Calf length_____

Date_____

Stockings Given ☐

RX Given ☐

Insurance ☐

Self Pay ☐

Size_____