Gilvydis Vein Clinic

Examination Questionnaire

Last Name: ________________________ First Name: ________________________ Date____/_____/____

Birthdate____/_____/____ Age: _________ Sex: M / F # of pregnancies: ____ Weight ______ Height ______

Name of Doctor Who Told You About Us: ____

Primary Care Physician ____

General Medical History
List past and present medical conditions 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: Rx and Supplements: **Include dose and how often you take the medication**:

____

____

____

Smoking history: Never Former smoker Year Quit ________ Current smoker ________ PPD

Vein History

Are the problems you are having with your legs interfering with your daily activities? (Please circle all that apply):

Right leg only **Left leg only** **Both legs**

Walking *Work Exercise Stairs Kneeling Social Activities Sleeping

Other: ____

Do your symptoms interfere with daily lifestyle activities? (Please circle one of the following):

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

* Have you ever worn compression stockings or socks Y / N When?______________(knee-high or thigh-high)

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 or spider veins?   Yes   No

***If Yes, please explain treatment and leg treated: ____

Family History

	Venous Ulcer	Varicose Veins	DVT	PE	Phlebitis	PVD	Leg Swelling	Heart Murmur
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brother or Sister	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother or Grandfather	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother or Grandfather	☐	☐	☐	☐	☐	☐	☐	☐

☐ **No known 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 defects)	_____	_____
Heart Murmur	_____	_____
Blood Clots	_____	_____
Atrial Fibrillation	_____	_____
Congestive Heart Failure	_____	_____
Headaches	_____	_____
Migraines	_____	_____

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

ANSWER THE FOLLOW IF OVER 65 YEARS OLD:

1. Have you had the pneumonia vaccine? **Yes; Date(s)**_______________ **No** **Decline to respond**
2. Do you have an advance directive (Healthcare living will/ power of attorney)? **Yes** **No** **Decline to respond**

   If yes, Name of Power of Attorney: ____

BELOW TO BE COMPLETED BY OFFICE STAFF

BP _____/_____ Pulse __________

Right leg	**Left leg**	
		Date_____________
Ankle_________	Ankle_________	Stockings Given ☐
Calf___________	Calf___________	RX Given ☐
Thigh__________	Thigh__________	Insurance ☐
Leg length_______	Leg length______	Self Pay ☐
Calf length______	Calf length______	

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