HUDSON PRO ORTHOPAEDICS & SPORTS MEDICINE

Patient Intake Form

Welcome to Pacific Vein Care. Please fill out this health history. We hope you enjoy your experience.

Name:_____

Address:_____

City:_____ State:____ Zip:_____

May we add your address to our mailing list? ___ Yes ___Nc

How did you hear about us?_____

Reason for your visit:_____

ALLERGIES? ☐ Yes ☐ No

If yes, please explain:_____

_____

Please indicate any reactions to meds, adhesives, rubber, latex and type of reaction i.e. hives, shock, etc.

_____

List all current medications and prescriptions:

Date:_____

Gender: ☐ Female ☐ Male

Date of Birth:_____

SS#:_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary ☐ Home#:_____

☐ Work#:_____

☐ Cell#:_____

May we call you at the above numbers to confirm appts? ___Yes ___ No

E-mail address:_____

May we notify you about appointments and specials by email? ___Yes ___No

(We do not disclose this information to anyone)

Do you smoke? ☐ Yes ☐ No ☐ Quit ☐ Staff Counseled

When did you quit_____ (year) How long did you smoke_____ (years)

Ht:_____ Wt:_____#

Primary Language_____

Emergency Contact:_____Phone #_____

Relation to patient:_____

Directions: Please answer the following questions. Provide estimates for dates of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery or laser treatments? ☐ Yes ☐ No
   If yes, when and which leg?_____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on your leg?_____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when?_____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when?_____
5. For women patients, # of pregnancies_____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other_____	☐ Yes	☐ No

Patient History

1. Do you experience any of the following in your legs?

Aching/pain?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Heaviness?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Tiredness/fatigue?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Itching/burning?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Swollen ankles?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Leg cramps?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Restless legs?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Throbbing?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Hyper pigmentation?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Varicose Veins	☐ Yes	☐ No	☐ One Leg	☐ Both Legs
Ulcers?	☐ Yes	☐ No	☐ One Leg	☐ Both Legs

   Other?_____
2. Have your vein symptoms worsened in recent months? ☐ Yes ☐ No
3. Do you take any medications for pain (i.e., Advil, Motrin)? ☐ Yes ☐ No
   If yes, what medication do you take and how many times / strength per day?

_____

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No

If yes, how long per day do you elevate and does it help?

_____

5. Do you exercise? ☐ Yes ☐ No

If yes, what kind of exercise and how often?

_____

6. Do you wear compression stockings? ☐ Yes ☐ No

If yes, what type and gradient? How long have you worn them?

_____

7. Do you have problems walking? ☐ Yes ☐ No

If yes, how does it effect you?_____

8. What type of work do you do?_____

How long do you stand (hours per day) at work?_____ at home?_____

9. Do you experience migraines?_____with auras?_____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No

If yes, when and what type of test and where on the leg?_____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

_____ _____

Patient Signature Date

Patients: Please stop here. The physician and/or staff may go over additional questions with you.

12. B/P_____ P_____ R_____ Temp_____ O_2Sat_____

Pictures Taken: ☐ Yes ☐ No _____

Measurements: Right Calf Circ._____cm Right Ankle Circ._____cm

Left Calf Circ._____cm Left Ankle Circ._____cm

Staff completing form and Consultation:_____

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