Patient Intake Form

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

Name:____

Date:____________________

Address:____

Gender: ☐ Female ☐ Male

City:__________________ State:____ Zip:__________
May we add your address to our mailing list? ___ Yes ___No

Date of Birth:____________________________________

SS#:____

How did you hear about us?_____________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Reason for your visit:____________________________

Primary
☐ Home#:____

ALLERGIES? ☐ Yes ☐ No

If yes, please explain:___________________________

____

☐ Work#:____

☐ Cell#:____
May we call you at the above numbers to confirm appts? ___Yes ___ No

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

____

E-mail address:_________________________________
May we notify you about appointments and specials by email? ___Yes ___No
(We do not disclose this information to anyone)

List all current medications and prescriptions:

____

____

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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