Sandman Center for Veins

Melissa Sandman, M.D.

Vein History & Health Form

Date: ____/____/____ **Name:** _____

DOB: ____/____/____ **Primary Care Provider:** _____

What specific signs/symptoms have you experienced in your legs?

□Leg aching □Leg burning □Leg discoloration □Leg cramping
□Leg swelling □Leg fatigue □ Leg heaviness □Leg itching
□Leg pain □Leg restlessness □Leg swelling □Leg throbbing
□Leg jumpiness

Do you have symptoms in your:

□ Right leg only □ Left leg only □ Both legs

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

Have you had previous vein treatment? □ yes □ no

Indicate which prior vein treatments you have had: (check all that apply)

□ sclerotherapy injections □ surgical ligation □ surgical vein stripping
□ ambulatory phlebectomy □ endovenous laser ablation □ radiofrequency closure
□ spider vein treatment

Have you ever had any of the following?

□ deep vein thrombosis (DVT) □ phlebitis (vein tenderness) □ leg ulcers (slow healing wounds)
□ pulmonary embolism (PE) □ ruptured or bleeding veins □ arterial disease

Have you ever worn compression hose? □ yes □ no
If yes, how for long? _____

List your current medications: □ no current medications, vitamins, supplements

_____

_____

Surgical history (list any surgeries and dates, if you know):

_____ Year: _____

_____ Year: _____

_____ Year: _____

System Review: (circle)

General:		
Good general health lately	Yes	No
Recent weight change	Yes	No
Fatigue	Yes	No
Fever	Yes	No

Eyes/Ears/Nose/Throat:		
Headaches	Yes	No
Vertigo/Dizziness	Yes	No
Change in vision	Yes	No
Difficulty hearing	Yes	No
Nose bleeds	Yes	No
Dental difficulties	Yes	No
Mouth sores	Yes	No
Neck stiffness	Yes	No
Neck pain	Yes	No
Sore throat	Yes	No

Cardiovascular:		
Heart trouble	Yes	No
Chest pain/angina pectoris	Yes	No
Palpitations	Yes	No
Short of breath when walking	Yes	No
High blood pressure	Yes	No
Swelling of ankles	Yes	No
Leg pain while walking	Yes	No
Easy bruising	Yes	No

Respiratory:		
Shortness of breath	Yes	No
Wheezing/Cough	Yes	No
Respiratory Infections	Yes	No
Spitting up blood	Yes	No
Tuberculosis exposure	Yes	No

Obstetrics/Gynecology:		
Number of pregnancies	_____	
Number of births	_____	
Any bleeding complications	Yes	No
Any clotting complications	Yes	No

Gastrointestinal:		
Change in appetite	Yes	No
Trouble swallowing	Yes	No
Indigestion	Yes	No
Abdominal pain	Yes	No
Heartburn	Yes	No
Nausea/vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Blood in stool/hemorrhoids	Yes	No

Genitourinary:		
Frequent urination	Yes	No
Blood in urine	Yes	No
Kidney stones	Yes	No
Kidney/bladder infections	Yes	No
Incontinence	Yes	No

Musculoskeletal:		
Muscle pain or cramps	Yes	No
Joint pain/stiffness/swelling	Yes	No
Limitation of movement	Yes	No
Weakness of muscle/joints	Yes	No
Back pain	Yes	No
Difficulty walking	Yes	No

Neurological:		
Seizure disorder	Yes	No
Memory difficulties	Yes	No
Tremors	Yes	No
Changes in speech	Yes	No
Sensory disturbances	Yes	No
Motor disturbances	Yes	No
Anxiety	Yes	No
Depression:	Yes	No
Psychiatric hospitalizations	Yes	No
Insomnia	Yes	No

If answered yes to any of the above, please explain:

Patient Medical History:

□ Arthritis
□ Cancer
□ Asthma
□ Heart disease
□ Blood disorder
□ Liver disease
□ Stroke
□ Other _____

□ Bleeding Tendency
□ Diabetes
□ High blood pressure
□ Kidney disease
□ Lung disease
□ Seizure disorder
□ Thyroid disease

Family Medical History: (please note in space provided your relation to them)

□ Arthritis _____ □ Bleeding Tendency _____
□ Cancer _____ □ Diabetes _____
□ Asthma _____ □ High blood pressure _____
□ Heart disease _____ □ Kidney disease _____
□ Blood disorder _____ □ Lung disease _____
□ Liver disease _____ □ Seizure disorder _____
□ Stroke _____ □ Thyroid disease _____

Do you have a family history of vein disease? Yes No
Any family history of blood clots? Yes No

Do you smoke? Yes No If yes, how much a day? _____
Do you exercise? Yes No If yes, what activities? _____
Are you currently working? Yes No What is your occupation? _____
Sit/stand for prolonged periods? Yes No

Are you allergic to any of the following products:

□ Lidocaine
□ Sodium Bicarbonate
□ Valium
□ Penicillin/Antibiotics
□ Latex
□ Epinepherine
□ Heparin
□ Ibuprofen
□ Nitroglycerine
□ Sodium Tetradecyl Sulfate

Any other known drug allergies? _____

I verify that the above answers are true to my knowledge and belief.

_____ _____
Date Patient Signature

By Physician:

_____ _____
Date Melissa A. Sandman, M.D.