Rose City Vein Center

PATIENT CONSULT FORM

Date _____

Name _____ DOB _____

Please indicate how your varicose vein symptoms impact specific activities of daily living:

1. *Do you have pain when taking a shower or bath?* **Y N**
2. *Do you have any bleeding from the veins?* **Y N**
3. *Does getting dressed hurt?* **Y N**
4. *Does it hurt if you bump them?* **Y N**
5. *Does it hurt to cross your legs?* **Y N**
6. *Do you have pain with meal preparation?* **Y N**
7. *Do you have pain when doing household chores?* **Y N**
8. *Does it hurt to garden or mow the grass?* **Y N**
9. *Do you have pain with exercise?* **Y N**
10. *Do you have pain when grocery shopping?* **Y N**
11. *Do you have pain when you bend or squat?* **Y N**
12. *Does it hurt when you are sleeping?* **Y N**
13. *Does it hurt when your dog or cat jump on your legs?* **Y N**
14. *Does it hurt to sit for an extended period of time?* **Y N**
15. *Does it hurt to stand for an extended period of time?* **Y N**
16. *Do you bruise easily?* **Y N**
17. *Weight change +/- 10 lbs in the past 30 days* **Y N**

Please list any other symptoms in your legs: _____

Approximately when or how long have you been noticing your symptoms? _____

Have you used medical grade compression stockings (minimum of 20mmHg)? **Y N** Since? _____

Past Medical History: (surgeries, hospitalizations and illness) _____

_____ _____

_____ _____

Personal history of Heart Disease? **Yes No** Do you have stents? **Yes No**

Medications: Allergies:

_____ _____

_____ _____

SOCIAL HISTORY:

Marital Status: **Single Married Widowed Separated Divorced** # of Children _____

Do you/did you ever smoke? **Yes No** How long? _____ Packs/day _____

FAMILY HISTORY:

Father: **Living/Deceased** Age _____ Illnesses/Cause of Death _____

Mother: **Living/Deceased** Age _____ Illnesses/Cause of Death _____

Family history of Heart Disease? **Yes No** Who? _____ Age? _____

Patient Signature _____ ***Date*** _____

To be completed by Physician Assistant

Class:

- ☐ 0- Asymptomatic
- ☐ 1- Spider, reticular veins Telangiectasias
- ☐ 2- Varicose veins
- ☐ 3- Edema
- ☐ 4- Skin changes
- ☐ 5- Healed ulcer
- ☐ 6- Active ulcer

Vitals:

Temp: _____ **sp02:** _____

Pulse: _____ **BP:** _____

Ht: _____ **Wt:** _____

Respiration: _____