Chippewa Valley
VEIN CENTER
AND ENDOVASCULAR SPECIALISTS

Venous History and Physical

Date: _____

Your Name: _____ Date of Birth: _____ Age: ____ Sex: ❑ M ❑ F

Primary Physician: _____ Referred By: _____ ❑ Self

Who should receive a letter regarding today's visit: ❑ Primary Physician ❑ Referring Physician ❑ Other _____

Chief Complaint: *Please describe the vein problems you are experiencing.*

_____

_____

Vein Symptoms/History of Present Illness: *Please check all that apply.*

R	L		R	L		R	L/Y	
❑	❑	*Painful veins*	❑	❑	*Skin color changes*	❑	❑	*Compression stockings >3 months*
❑	❑	*Legs feel heavy*	❑	❑	*Phlebitis*	❑	❑	*Use leg elevation for symptoms*
❑	❑	*Leg cramps or aches*	❑	❑	*Blood Clots or DVT*		❑	*Use pain meds for symptoms*
❑	❑	*Leg burning, itching*	❑	❑	*Ulcerations at ankles*		❑	*Regular exercise routine*
❑	❑	*Leg swelling*	❑	❑	*Prior sclerotherapy*		❑	*Weight loss program*
❑	❑	*Restless legs*	❑	❑	*Prior vein stripping*		❑	*Prolonged sitting or standing daily*
❑	❑	*Veins are enlarging*	❑	❑	*Symptoms worse w/ standing*		❑	*Symptoms affect daily activity/work*

_____

_____

_____

_____

Medications: *Include oral contraceptives, tetracycline, aspirin, Plavix, Coumadin*

_____

_____

_____

_____

_____

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Allergies: *Include iodine, contrast dye, latex*

_____

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Past Medical History: *Please indicate if you have or have had any of the following.*

❑ *High blood pressure* ❑ *High cholesterol* ❑ *Diabetes* ❑ *Kidney failure*
❑ *Heart disease* ❑ *Cancer* ❑ *Lung disease* ❑ *Stroke*
Details/other:

Past Surgical History: *Please indicate if you have had any of the following*

❑ *Gallbladder removal* ❑ *Heart bypass* ❑ *Hernia repair* ❑ *Carotid artery surgery*
❑ *Bowel surgery* ❑ *Leg / arm bypass*
Details/other:

Family History: *Please list any health conditions in your family, especially your mother, father, sisters, brothers.*

_____

_____

❑ *Varicose veins in family. Who:* _____

Social History:

❑ *Smoke* *Packs per day?* ____ *Years?* ____ *Quit? When?* _____
❑ *Drink alcohol* ❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Live alone*
*Occupation:*_____

Review of systems: *Please indicate if you have any of the problems listed below.*

General:
- ❑ *Fever or chills*
- ❑ *Night sweats*
- ❑ *Loss of appetite*
- ❑ *Fatigue*
- ❑ *Weight loss or gain*

Eyes:
- ❑ *Glasses or contact lenses*
- ❑ *Blurred or double vision*
- ❑ *Visual loss*
- ❑ *Pain*
- ❑ *Redness*

Ear, Nose, Mouth, Throat:
- ❑ *Hearing loss*
- ❑ *Ear pain*
- ❑ *Ringing in ears*
- ❑ *Sinus congestion*
- ❑ *Frequent nose bleeds*
- ❑ *Hoarseness*
- ❑ *Difficulty swallowing*

Cardiovascular:
- ❑ *Chest pain*
- ❑ *Palpitations*
- ❑ *Heart murmur*
- ❑ *Heart attack*
- ❑ *Pacemaker*
- ❑ *Congestive heart failure*
- ❑ *Stroke*
- ❑ *Leg swelling*

Respiratory:
- ❑ *Chronic cough*
- ❑ *Shortness of breath*
- ❑ *Wheezing*
- ❑ *Emphysema*
- ❑ *Asthma*
- ❑ *Tuberculosis or TB*

Gastrointestinal:
- ❑ *Heartburn/reflux*
- ❑ *Nausea/vomiting*
- ❑ *Abdominal pain*
- ❑ *Diarrhea*
- ❑ *Constipation*
- ❑ *Change in BMs*
- ❑ *Bloody/black stool*
- ❑ *Vomiting blood*
- ❑ *Jaundice*
- ❑ *Liver disease*
- ❑ *Hepatitis*
- ❑ *Stomach or duodenal ulcers*

Genitourinary:
- ❑ *Frequent urination*
- ❑ *Painful urination*
- ❑ *Blood in urine*
- ❑ *Kidney stones*
- ❑ *Prostate problems*
- ❑ *Kidney disease or failure*

Musculoskeletal:
- ❑ *Joint pain or stiffness*
- ❑ *Joint swelling*
- ❑ *Joint replacement*
- ❑ *Back pain*
- ❑ *Leg pain with walking*
- ❑ *Muscle weakness*

Skin and Breast:
- ❑ *Easy bruising*
- ❑ *Rash*
- ❑ *Sores/ulcers*
- ❑ *Hair loss*
- ❑ *Itching*
- ❑ *Breast lumps*
- ❑ *Nipple Discharge*
- ❑ *Abnormal Mammogram*

Neurological:
- ❑ *Frequent headaches*
- ❑ *Numbness/tingling*
- ❑ *Seizures*
- ❑ *Head injury*
- ❑ *Stroke*
- ❑ *Memory loss*
- ❑ *Dizziness*

Psychiatric:
- ❑ *Anxiety*
- ❑ *Depression*
- ❑ *Insomnia*
- ❑ *Drug abuse*
- ❑ *Alcohol abuse*

Endocrine:
- ❑ *Diabetes*
- ❑ *Thyroid problems/goiter*
- ❑ *Heat or cold intolerance*

Hematologic/Lymphatic:
- ❑ *Easy bruising*
- ❑ *Easy bleeding*
- ❑ *Anemia*
- ❑ *Enlarged glands*
- ❑ *AIDS or HIV positive*

Allergic / Immunologic:
- ❑ *Allergy to penicillin/other antibiotic*
- ❑ *Allergy to iodine or IVP dye*
- ❑ *Allergy to local anesthetic*
- ❑ *Food allergies*
- ❑ *Reaction to general anesthesia*

Gynecological:
- ❑ *Irregular or heavy periods*
- ❑ *Bleeding between periods*
- ❑ *Menopause*

❑ **None of the above**

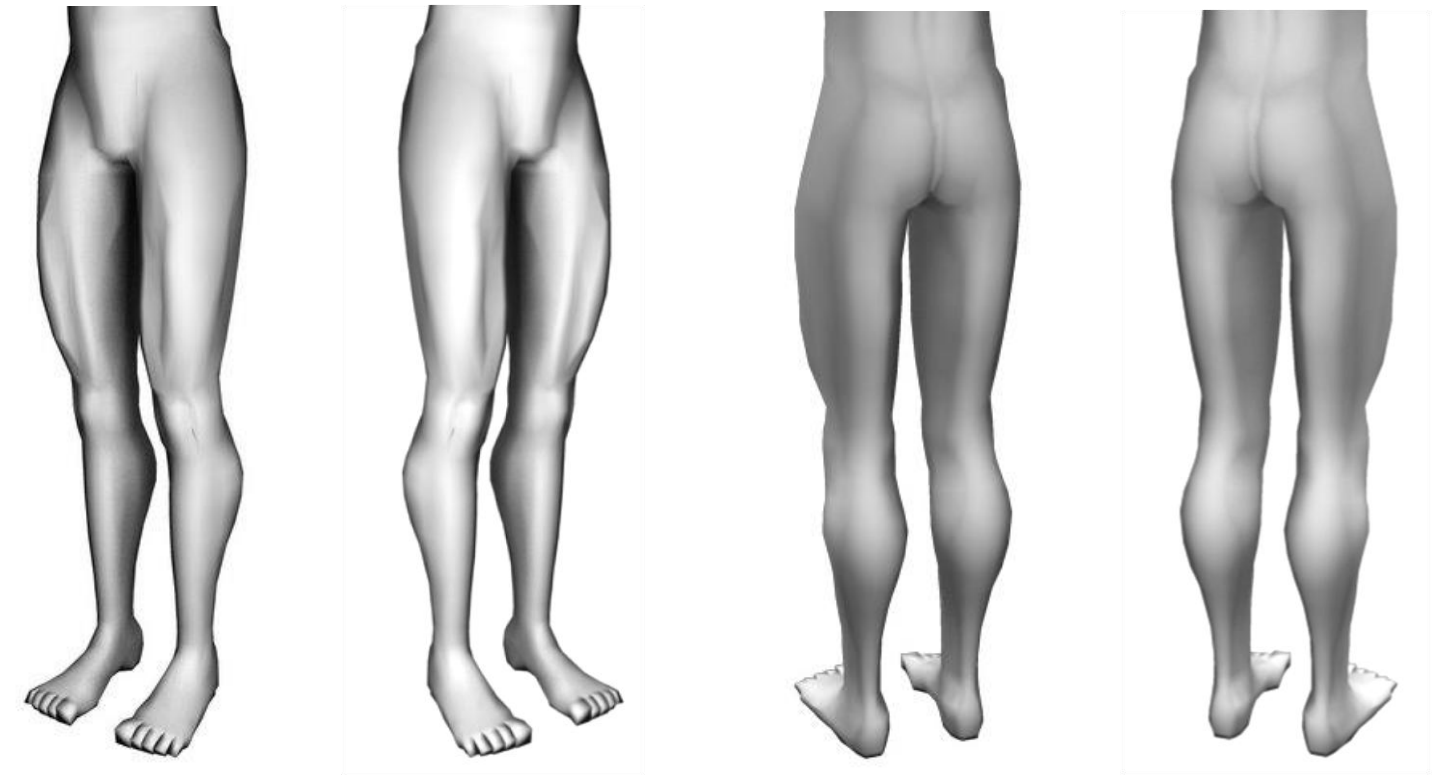
Signature: _____ **Date: _____**

Physical Exam: *For office use*

Vital Signs	Temp:	BP:	HR:	RR:	Weight:

Leg examination:

R	L		R	L		R	L		R	L	
❑	❑	**Spider Veins (SV)**	❑	❑	**Varicose Veins (VV)**	❑	❑	**Active Ulcers (AU)**	❑	❑	**Healed Ulcers (HU)**
❑	❑	**Pigmentation (P)**	❑	❑	**Numbness (N)**	❑	❑	**Edema (E)**	❑	❑	



Right **Left** **Right** **Left** **Left** **Right** **Left** **Right**

❑ Photograph Taken ❑ Hose measurement Taken: _____

Data (Lab/Imaging Results): _____

_____

ASSESSMENT:

❑ Varicose veins with inflammation ❑ Venous insufficiency ❑ Venous ulcers ❑ VV w other cx (edema, pain, swelling)

❑ Leg pain with venous etiology ❑ Telangiectasias/spider veins ❑ Thrombophlebitis ❑ Asymptomatic VV

Details/other:

_____

_____

PLAN:

❑ Venous duplex ❑ Ambulatory phlebectomy ❑ Sclerotherapy

❑ Endovenous closure ❑ US guided sclerotherapy **Time spent with patient:_____**

Details/other:

_____

_____

Nurses Initials: _____ **Physician Signature:** _____ **Date:** _____