ReinckeVein center

PHYSICAL & HEALTH INFORMATION

Name: _____
Last Name First Name M.I.

Date of Birth _____ Please indicate your: Height (Feet & Inches) _____ Weight (lb) _____

Chief Complaint:

Explain reason for office visit: _____

_____

HPI:

Please check ALL that apply:

- ☐ Aching sensation
- ☐ Heaviness
- ☐ Pain while standing
- ☐ Swelling
- ☐ Redness
- ☐ Tender/warm to touch
- ☐ Skin discoloration
- ☐ Spider veins
- ☐ Varicose veins (large ropy veins)
- ☐ Bleeding veins
- ☐ Ulcer (an "open sore")
- ☐ Itching
- ☐ Dry, flaky skin over varicose veins
- ☐ Burning
- ☐ Restless legs
- ☐ Tired legs
- ☐ Calf and/or foot cramps at night ("Charlie horse")

When did your vein problems first appear, and when did you notice the symptoms? (days, months, years)

_____

Does anything make your symptoms worse? (standing for more than 30 min, sitting traveling, etc.)

_____

Does anything help relieve your symptoms? (resting with your legs up, compression hose, ibuprofen, etc.)

_____

Do you wear compression hose? ☐ Yes ☐ No

Current Medications:

please include over-the-counter products (aspirin, vitamins, etc.)

_____

_____

_____

Have you been vaccinated? COVID-19 ☐ Yes ☐ No Flu ☐ Yes ☐ No

Past Medical History:

Check if you have any of the following:

- ☐ Arthritis
- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Asthma
- ☐ Stroke (recovered)
- ☐ Diabetes (A1C:_____)
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Bleeding/Bruising
- ☐ Cancer/Tumors
- ☐ Thyroid Disease
- ☐ Mental Illness
- ☐ COPD
- ☐ Other medical issues: _____

Past Medical History (continued):

Have you ever had a blood clot? ☐ Yes ☐ No Were you put on blood thinners? ☐ Yes ☐ No

If so, what medication was it and how long were you on it? _____

Have you ever sustained an injury from a fall? ☐ Yes ☐ No When?___/___/____

Have you ever been treated for your vein problem? ☐ Yes ☐ No

If yes, by whom and type of treatment? (Injections, heat procedures, surgery, etc.): _____

_____

Medication Allergies:
please indicate reaction

_____

_____

Women Only:

Number of pregnancies: _____ Number of deliveries: _____
Last Mammogram ___/___/___ Where there any abnormalities? ☐ Yes ☐ No
Has it been less then a year since your period? ☐ Yes ☐ No If so when? ___/___/____
Are you pregnant or breastfeeding ☐ Yes ☐ No

Hospitalizations and Surgeries (when and type):

_____

_____

_____

Family History:
Please indicate if there has been any FAMILY history of any of the following *(please indicate who on the lines provided)*:

- ☐ Vein Disease_____
- ☐ Hypertension (high blood pressure) _____
- ☐ Heart Disease_____
- ☐ Other medical issues: _____
- ☐ Heart Attack_____
- ☐ Cancer_____
- ☐ Blood Clots_____

Social History:
Occupation: _____ Do you sit or stand frequently? ☐Sit ☐Stand ☐Neither
How often do you exercise? ☐ Rarely ☐ Moderate ☐ Frequently Do you travel frequently? ☐ Yes ☐ No

Alcohol use (beer/wine/liquor): ☐ Yes ☐ No Drinks per week:_____
Smoking History: ☐ Yes ☐ No _____ Packs per week _____Years smoked _____ Years since you quit
Recreational drug use (marijuana): ☐ Yes ☐ No

Do you have chronic pelvic pain? ☐ Yes ☐ No Do you have pelvic pain during sex? ☐ Yes ☐ No
Any bulging veins on the pelvis or groin area? ☐ Yes ☐ No Do you feel heaviness in the pelvic area? ☐ Yes ☐ No
Do you have any foot/ankle pain? ☐ Yes ☐ No Describe the pain: _____
Are you seeing a podiatrist? ☐ Yes ☐ No Podiatrist Name:_____

Review of Systems:
Do you have any of the following (please check all applicable)?

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Significant Weight Loss
- ☐ Other:_____

Eyes
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Glasses or Contacts
- ☐ Other:_____

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Other:_____

Cardiac
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Orthopnea (difficulty breathing while lying down)
- ☐ Swelling of Extremities
- ☐ Other:_____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Heartburn
- ☐ Jaundice
- ☐ Other:_____

Genitourinary
- ☐ Hematuria (blood in urine)
- ☐ Polyuria (frequent urination)
- ☐ Incontinence (urinary leakage)
- ☐ Difficulty start/stop stream of urine
- ☐ Other:_____

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Other:_____

Skin
- ☐ Rash/Sores
- ☐ Lesions/Open Wounds
- ☐ Itching
- ☐ Burning
- ☐ Bruising
- ☐ Other:_____

Neurologic
- ☐ Seizures
- ☐ Headache/Migraine - visual aura (☐ yes ☐ no)
- ☐ Memory Loss
- ☐ Dizziness/Fainting
- ☐ Other:_____

Psychosocial
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Suicidal Thoughts

_____

Patient or Responsible Party Signature Date

_____

Provider Signature Date