Review of Systems

Do you have or have you ever had any of the following? Please check all that apply.

CONTINUAL SYMPTOMS		**MUSCULOSKELETAL**	
Appetite loss	□ Yes □ No	Pain	□ Yes □ No
Dizziness	□ Yes □ No	Weakness	□ Yes □ No
Fatigue	□ Yes □ No	Numbness	□ Yes □ No
General Weakness	□ Yes □ No	Joint Pain	□ Yes □ No
Weight loss	□ Yes □ No	Other:	
Other:		**EAR/ NOSE/ THROAT/ MOUTH**	
EYES		Ear infection/ Sore Throat	□ Yes □ No
Blurred/ Double Vision	□ Yes □ No	Nose Bleeds	□ Yes □ No
Cataracts	□ Yes □ No	Sinuses/ Seasonal Allergies	□ Yes □ No
Pain	□ Yes □ No	Other:	
Other:		**GENITOUINARY**	
NEUROLOGICAL		Urine Retention	□ Yes □ No
Tremors/ Seizures	□ Yes □ No	Painful / Bloody Urination	□ Yes □ No
Dizzy Spells/ Fainting	□ Yes □ No	Urinary Frequency	□ Yes □ No
Neuropathy	□ Yes □ No	Incontinence	□ Yes □ No
Numbness/ Tingling	□ Yes □ No	Other:	
Migraines	□ Yes □ No	**RESPIRATORY**	
Other:		Wheezing/ Cough	□ Yes □ No
GASTROINTESTINAL		Sleep Apnea	□ Yes □ No
Abdominal Pain	□ Yes □ No	Shortness of Breath	□ Yes □ No
Nausea/ Vomiting	□ Yes □ No	Asthma	□ Yes □ No
Indigestion/ Heartburn	□ Yes □ No	**HEMTOLOGIC/ LYMPHATIC**	
Diarrhea/ Constipation	□ Yes □ No	Swollen Glands (neck)	□ Yes □ No
Reflux	□ Yes □ No	Blood Clotting Problem	□ Yes □ No
Other:		Hepatitis	□ Yes □ No
CARDIOVASCULAR		HIV/ AIDS	□ Yes □ No
Chest Pain	□ Yes □ No	DVT/ PE	□ Yes □ No
Heart Murmur	□ Yes □ No	Diabetes	□ Yes □ No
High Blood Pressure	□ Yes □ No	**PSYCHOLOGIC**	
Arrhythmia	□ Yes □ No	Nervousness	□ Yes □ No
Varicose Veins	□ Yes □ No	Anxiety	□ Yes □ No
Leg Swelling	□ Yes □ No	Depression	□ Yes □ No
Other:		Other:	

Office use only: (comments/ notes):

_____

_____

_____

_____

Patient Signature: _____ ***Date:*** _____

Reviewed with patient by: _____

Patient Health History

Name: _____ DOB: _____ Date: _____

Reason for Visit:

_____

Physician notes:

_____

_____

_____

Current Medication:

Name	**Dose/ Strength**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Medication or any other substances?

_____

_____

Past surgical history:

_____

_____

_____

Social history:

Marital Status: Single Married Divorced Widowed

Exercise: _____ If yes, how often? _____

Tobacco: _____ Packs per day _____

Alcohol: _____ Drinks per day _____

Height _____ Weight _____

Family history:

Parents: Mother Living/ Deceased Cause of Death _____

Father Living/ Deceased Cause of Death _____

Number of brothers/ sisters _____ Number of children _____

Varicose Veins Patient Questionnaire

Patient: _____ Date: _____

1. Have you or anyone in your family been diagnosed with varicose veins?
_____ No _____Yes, please list:
_____

2. Do you have varicose veins that exhibit any of the following characteristics?
[ ] Large, bulging veins of the legs
[ ] Swollen, red or warm to the touch
[ ] Skin discoloration or texture changes

3. Are you experiencing any of the following symptoms in your legs, ankles or feet?
[ ] Pain
[ ] Aching
[ ] Cramping
[ ] Heaviness / Fatigue
[ ] Burning or tingling sensation
[ ] Tender areas around the veins
[ ] Sores or skin ulcers near the ankle If yes, how long? _____
[ ] Swelling

4. How do your symptoms interfere with your daily living activities? _____
_____
_____

5. Have you previously attempted any of the following conservative treatments without success?
[ ] Weight loss
[ ] Elevating legs If yes, how often?
_____
[ ] Avoiding long periods of sitting or standing
[ ] Compression stockings If yes, how long?
_____
[ ] Pain management If yes, list medications (Advil, Tylenol, Ibuprofen, etc.)
_____

6. How long have you had pain or other symptoms of varicose veins? _____

Release to Use Photos

[ ] I agree to allow the physician to use photos taken of my legs to be released to my insurance carrier(s).
[ ] I agree to allow the physician to use photos taken of my legs to be used in presentations regarding the treatment of varicose veins. The photos are not to be sold or used for profit in any way. I understand that any of my personal information, such as my name or date of birth will not be used with my photos.

Printed Name: _____

Signature: _____ Date: _____