VEIN CENTER
OF NORTH TEXAS

Hx-PE

Name: _____ Age: _____
Date of Birth: _____ Today's Date: _____
Friends or relatives who have seen us: _____
How did you hear about us? _____

Please list all doctors (and phone #s) you see or have seen:
Doctor that consulted Dr. Hayes: _____
Primary Care Physician: _____
Specialist Physicians: _____

PRIMARY REASONS FOR YOUR VISIT:

☐ Leg Edema/Swelling ☐ Varicose Veins ☐ Restless Legs ☐ Skin Discoloration/Thickening
☐ Leg Ulcers ☐ Leg Pain /Aching ☐ Cosmetic Appearance ☐ Other: _____

SIGNS / SYMPTOMS:

☐ Aching / Pain _____
☐ Tenderness _____
☐ Cramps _____
☐ Swollen Ankles _____
☐ Blood Clots _____
☐ Itching _____
☐ Tingling _____
☐ Heaviness _____
☐ Tiredness _____
☐ Phlebitis/Infection _____
☐ Redness _____
☐ Bleeding _____
☐ Skin Ulceration _____
☐ Varicose Veins _____
☐ Restless Legs _____
☐ Vaginal/Pelvic Discomfort _____
☐ Other _____

How many years have you had these symptoms? _____

What activity makes it worse?
☐ Prolonged Standing ☐ Work
☐ Prolonged Sitting ☐ Walking
☐ Housekeeping ☐ Yard Work
☐ Travel ☐ Exercise

What conservative measures have you tried?
☐ Leg Elevation _____
☐ Avoid prolonged standing _____
☐ Weight Reduction _____
☐ Compression Stockings
☐ Walking / Exercise _____
☐ Baths / Hot Soaks _____
☐ Pain Meds / Analgesics _____
☐ Other Measures: _____

Have your veins been treated before? ☐ Y ☐ N
☐ Stripping ☐ Injections ☐ Phlebectomy ☐ Laser
By Whom? _____ When? _____

ALLERGIES: ☐ None ☐ Yes
(If Yes, List the medication and reaction)

MEDICATIONS: *(List all Medications, Dosages, and Frequency. Include over-the-counter medications and supplements.)*

Vaccinations: Flu Shot ☐ Y ☐ N Pneumonia or Pneumococcal Vaccine ☐ Y ☐ N

over>

CARDIAC Hx: YES/NO

- Cardiac Cath / When_____ ☐ ☐
- Heart Stent / When_____ ☐ ☐
- Heart Attack ☐ ☐
- Heart Bypass / When_____ ☐ ☐
- Heart Disease ☐ ☐
- Heart Failure ☐ ☐
- Heart Mitral Valve Prolapse ☐ ☐
- Heart Murmur ☐ ☐
- High Blood Pressure ☐ ☐
- High Cholesterol ☐ ☐
- Angina / Chest Pain ☐ ☐
- Pacemaker ☐ ☐

Cardiologist: _____

Other: _____

VASCULAR Hx: YES/NO

- Aneurysm / Type _____ ☐ ☐
- Blood Clots / DVT ☐ ☐
- Free Bleeding ☐ ☐
- Phlebitis / Vein Infection ☐ ☐
- Pulmonary Embolus ☐ ☐
- Restless Legs ☐ ☐
- Sickle Cell ☐ ☐
- Stroke / TIA ☐ ☐
- Warfarin Use ☐ ☐
- Coagulopathy: Type_____ ☐ ☐

Other: _____

MEDICAL Hx: YES/NO

- Arthritis ☐ ☐
- Anemia ☐ ☐
- Cancer / Type_____ ☐ ☐
- Diabetes Mellitus ☐ ☐
- Emphysema / Asthma / COPD ☐ ☐
- Fibromylgia ☐ ☐
- Hepatitis A / B / C ☐ ☐
- HIV / AIDS ☐ ☐
- Kidney Disease ☐ ☐
- Liver Disease ☐ ☐
- Migraines / Headaches ☐ ☐
- Sleep Apnea ☐ ☐
- Stomach Ulcers ☐ ☐
- Current Wheelchair Use ☐ ☐
- Colonoscopy When_____ ☐ ☐
- Mammogram When_____ ☐ ☐
- Dexa Scan (bone scan) When_____ ☐ ☐

Other: _____

LEG Hx: YES/NO

- Leg Infection ☐ ☐
- Leg Ulcers ☐ ☐
- Leg Trauma / Leg Injury ☐ ☐
- Lymphedema / Lymphangitis ☐ ☐
- Neuropathy ☐ ☐

Other: _____

GYNECOLOGIC Hx: YES/NO

- Pelvic Pain / Fullness ☐ ☐
- Pelvic Pain During Intercourse ☐ ☐
- Pelvic Pain w/ Menstrual Cycle ☐ ☐
- Pelvic Pain w/ Prolonged Study ☐ ☐
- Vulvar / Vaginal Varicosities ☐ ☐

Other: _____

FAMILY Hx:

- ☐ Restless Legs
- ☐ Varicose Veins
- ☐ Spider Veins
- ☐ Leg Ulcers
- ☐ Blood Clots
- ☐ Heart Disease
- ☐ Free Bleeding
- ☐ Cancer / Type_____
- ☐ Stroke

Other: _____

SURGICAL Hx: YES/NO

- Back Operation ☐ ☐
- Hysterectomy ☐ ☐
- Leg / Knee / Hip Operation ☐ ☐
- Neck Operation ☐ ☐
- Pacemaker / ICD ☐ ☐
- Thyroidectomy ☐ ☐
- Vein Operation / When_____ ☐ ☐
- Artery Operation ☐ ☐
- Heart Operation ☐ ☐
- Previous Anesthesia Problems ☐ ☐

Other: _____

SOCIAL Hx:

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Children: _____

Next of Kin: _____

Family Here Today: _____

Cigarette Use: ☐ Never

- ☐ Age when Started _____
- ☐ PPD _____
- ☐ Quit / When _____

Alcohol Use: ☐ Never

- ☐ Age When Started _____
- ☐ Drinks Per Week _____
- ☐ Quit / When _____

Drug Use: ☐ Never

- ☐ Type and Frequency _____

_____

- ☐ Quit / When _____

Depression: ☐ Yes ☐ No

Occupation: _____

- ☐ Retired
- ☐ Disabled / Reason _____

REVIEW OF Sx's: YES/NO

What are you feeling currently?

Constitution

- Fever / Chills ☐ ☐
- Night Sweats ☐ ☐
- Fatigue ☐ ☐

Cardiovascular

- Chest Pain ☐ ☐
- Chest Pressure ☐ ☐
- Palpitations ☐ ☐

Musculoskeletal

- Joint Stiffness ☐ ☐
- Joint Pain ☐ ☐
- Back / Neck Pain ☐ ☐

Endocrine

- Excessive Thirst / Urination ☐ ☐
- Hormone Problems ☐ ☐
- Thyroid Disease ☐ ☐

Urinary

- Kidney Stones ☐ ☐
- Blood in Urine ☐ ☐
- Painful Urination ☐ ☐
- Urine Incontinence ☐ ☐

Respiratory

- Shortness of Breath ☐ ☐
- Wheezing / Asthma ☐ ☐
- Heavy Snoring ☐ ☐

Neurological

- Convulsions / Seizures ☐ ☐
- Numbness / Tingling ☐ ☐
- Vertigo ☐ ☐

Hematologic

- Anemia ☐ ☐
- Free Bleeding ☐ ☐
- Sickle Cell ☐ ☐

Breast

- Breast Lumps / Pain ☐ ☐
- Nipple Discharge ☐ ☐

Gastrointestinal

- Irritable Bowel Syndrome ☐ ☐
- Yellow Jaundice ☐ ☐
- Diarrhea ☐ ☐

Gynecologic

- Number of Pregnancies
- Number of Live Births _____
- Hormone Therapy ☐ ☐
  Type_____
- Are You Breast Feeding? ☐ ☐
- Are You Pregnant or Planning to be Soon? ☐ ☐

PHYSICIAN STATEMENT:

I have reviewed and summarized the above with the patient and present family.

Kelsie Sarten:_____

Dr Hayes: _____

Date:_____

PATIENT STATEMENT:

I certify that, to the best of my knowledge, the above information is accurate and complete.

Signed: _____

Date:_____