IMPROVE YOUR QUALITY OF LIFE! SM

Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____ **Occupation:** _____

What symptoms brought you in today? (check all that apply)

__ Leg pain R L
__ Leg swelling R L
__ Leg tenderness R L
__ Discolored legs R L
__ Leg ulcer(s) R L
__ Pelvic pain
__ Pain in groin/genitals
__ Bulging veins
__ Restless legs
__ Blood clot R L

Have you ever had any of the following:	**Yes/No**	**Which Leg?**(please circle)
Injury requiring surgery to the leg or casting?	**Y N**	**Right Left**
Blood clot in the Deep Veins (DVT)?	**Y N**	**Right Left**
Phlebitis (Superficial veins, SVT)?	**Y N**	**Right Left**
Venous Stasis Ulcer?	**Y N**	**Right Left**
Sclerotherapy?	**Y N**	**Right Left**
LASER Treatment of the Legs?	**Y N**	**Right Left**
Vein Stripping?	**Y N**	**Right Left**
Phlebectomy?	**Y N**	**Right Left**
Thermal Ablation?	**Y N**	**Right Left**
Major Leg Surgery	**Y N**	**Right Left**

How did you hear about us? (Facebook ad, billboard, provider referral, friend, etc.):

_____

_____

Medical History- Please check all known medical problems:

__ High blood pressure	__ Hepatitis	__ IBS/Crohn's
__ Diabetes	__ Kidney disease	__ PCOS
__ Stroke	__ HIV/AIDS	__ Fibromyalgia
__ Heart disease	__ Anxiety/Depression	__ Chronic back pain
__ Lupus	__ Chest pain/heart attack	__ Endometriosis
__ Migraines	__ COPD/asthma	__ Blood disorder
__ Heart disease	__ Anemia	__ Other: _____

Current Medications: (Include hormones, pain medications & vitamins)

Medication	Dose	Frequency	Route (Oral, Injectable)

ALLERGIES:

Substance	Reaction/Sensitivity

Past Surgical History (please list all previous surgeries AND procedures):

Date/Procedure_____/_____
Date/Procedure_____/_____
Date/Procedure_____/_____
Date/Procedure_____/_____
Date/Procedure_____/_____
Date/Procedure_____/_____
Date/Procedure_____/_____

Family History:
Does anyone in your FAMILY of any of the following problems? (check all that apply & list which family member)

__ Varicose veins: _____
__ Stroke: _____
__ Clotting disorder: _____
__ Blood clot/DVT:_____

Social History:

Do you have an allergy to metal?	**Y**	**N**	What metal?_____
Are you allergic to iodine or shellfish?	**Y**	**N**	Reaction_____
Are you allergic to tape?	**Y**	**N**	What tape?_____
Are you latex sensitive?	**Y**	**N**	Reaction_____
Do you smoke?	**Y**	**N**	____packs/day ☐ vape ☐ pipe, cigar
Do you consume alcohol?	**Y**	**N**	____drinks/week ☐ beer/wine ☐ liquor
Do you consume recreational drugs?	**Y**	**N**	Type_____

Review of Systems:

Do you have any other health concerns or issues that are occurring TODAY? (please circle)

Constitutional	Fever, chills, loss of appetite, night sweats, dizziness
Ear/Nose/Throat	Runny nose, sore throat, ear pain, decreased hearing, ringing in ears
Eyes	Blurred vision, watery eyes, eye pain, vision loss
Cardiac	Chest pain, shortness of breath, left arm pain, palpitations
Respiratory	Cough, wheezing, shortness of breath
Gastrointestinal	Nausea/vomiting, abdominal pain, diarrhea
Genitourinary	Painful urination, frequent urination, waking at night to urinate
Musculoskeletal	Painful joints, change in walking ability
Neurological	Unexplained numbness, weakness, memory loss
Skin	Rash, itching, open wound that won't heal
Psychiatric	Anxiety, depression, panic attacks

Please sign and date below:

Patient Signature:_____ Date:_____

Stephen F. Daugherty, MD, FACS, RVT, RPhS

Sandra French, RN, MSN, FNP-BC

Date Reviewed:_____