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: (check/circle all that apply)

__ Injury requiring casting to the leg	**Right**	**Left**
__ Blood clot in the Deep Veins (DVT)	**Right**	**Left**
__ Vein Stripping	**Right**	**Left**
__ Thermal Ablation (RFA)	**Right**	**Left**
__ Foam Injections (ECA)	**Right**	**Left**
__ Major Leg Surgery	**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
__ Diabetes
__ Stroke
__ Heart disease
__ High Cholesterol
__ Migraines
__ Acid Reflux
__ Hepatitis
__ Kidney disease
__ HIV/AIDS
__ Anxiety/Depression
__ Chest pain/heart attack
__ COPD/asthma
__ Anemia
__ IBS/Crohn's
__ PCOS/Endometriosis
__ Fibromyalgia
__ Chronic back pain
__ Thyroid disease
__ Cancer
__ 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? (list who in your family this applies to)

__ 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 type?_____
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:

Are any of the problems below new for you 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:_____