Deak Vein NJ Clinic

In Office Laser Vein Treatment

Venous Medical History

Name____**Date**_________________________________

Primary Physician______________________________ **Date of Birth**__________________________

Please list any allergies you have: ____

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Reason you are seeking treatment for your veins:

Medical reasons ____________________

Cosmetic reasons ____________________

How long have you had the veins you are concerned about? ___________________________

Did your veins develop during a pregnancy? ____

Does prolonged sitting or standing aggravate your veins? ____________________________

Are your veins getting worse? ____

Have you ever had treatment for your veins, if yes where and what type of treatment?

____

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Do your legs ever (please circle if appropriate) Swell Ache Red and inflamed

Have you ever been treated for a blood clot in your legs, if yes when and which leg?

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Do you or have you ever worn compression hose, and if yes for how long and did it help your veins?

____

Please list any medications you are currently taking: _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Please circle any of the following medical problems you have:

High Blood Pressure	**Cancer**	**Heart Disease**
Lung Disease	**Diabetes**	**Liver Disease**

Please list any pertinent medical condition you have, that we have not listed:

____

Please list previous surgeries and dates ______________________________________

____

<u>Remainder to be filled out by nurses</u>

Upon examination patient has:

Spider veins involving:	**<u>Left</u>**		**<u>Right</u>**
Anterior thigh	**Lateral thigh**	**Anterior thigh**	**Lateral thigh**
Posterior thigh	**Posterior Calf**	**Posterior thigh**	**Posterior Calf**
Medial knee	**Anterior shin**	**Medial knee**	**Anterior shin**

Varicose Veins

involving: **<u>Left:</u>** **Right:**

Left		Right	
Anterior thigh	**Lateral thigh**	**Anterior thigh**	**Lateral thigh**
Posterior thigh	**Posterior Calf**	**Posterior thigh**	**Posterior Calf**
Medial knee	**Anterior shin**	**Medial knee**	**Anterior shin**

Picture Taken: ____________________________

Hose Measurement Taken_________________________

Any additional notes: ____

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Nurses

Signature ________________________________ **Date:** ________________

Physicians review/

signature____________________________ **Date:** ________________