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:** _____

_____

**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?**

_____

_____

**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?**

_____

_____

**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:**

| **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:** _____

_____

_____

**Nurses**

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

**Physicians review/**

**signature**_____ **Date:** _____