THUNDERBIRD
VEIN

Name_____

Date_____ DOB_____

How did you hear about us? (circle)

Primary Care Provider (PCP) Facebook

Previous patient, Family/friend

Other_____

I) Vein Health History

Veins problematic for _____Years

First Symptoms:

- ☐ Visible veins ☐ Both ☐ R ☐ L
- ☐ Pain ☐ Both ☐ R ☐ L
- ☐ Swelling ☐ Both ☐ R ☐ L
- ☐ Other_____

Current Symptoms:

Aching	☐ Both	☐ R	☐ L
Swelling	☐ Both	☐ R	☐ L
Fatigue	☐ Both	☐ R	☐ L
Itching	☐ Both	☐ R	☐ L
Burning	☐ Both	☐ R	☐ L
Throbbing	☐ Both	☐ R	☐ L
Tingling	☐ Both	☐ R	☐ L
Ulcers	☐ Both	☐ R	☐ L
Restless legs	☐ Both	☐ R	☐ L
Bleeding	☐ Both	☐ R	☐ L
Phlebitis	☐ Both	☐ R	☐ L
Dermatitis	☐ Both	☐ R	☐ L
Skin Color Change	☐ Both	☐ R	☐ L

Pregnancy History

- ☐ No Pregnancies How many?_____
- ☐ First noticed veins with pregnancy
- ☐ Veins worsened with pregnancy

History of blood clots? ☐ Yes ☐ No

- ☐ DVT ☐ Both ☐ R ☐ L
- ☐ Phlebitis ☐ Both ☐ R ☐ L

Occupation _____

Prolonged ☐ Sitting ☐ standing ☐ Both

Prior Vein Treatments

- ☐ Sclerotherapy ☐ Both ☐ R ☐ L
- ☐ Laser ☐ Both ☐ R ☐ L
- ☐ Stripping ☐ Both ☐ R ☐ L
- ☐ Phlebectomy ☐ Both ☐ R ☐ L
- ☐ Closure ☐ Both ☐ R ☐ L
- ☐ Other_____

II) Conservative Measures attempted to Control Symptoms

****Compression Stocking Use**

(you are required to document your current and past stocking use for treatment pre-authorization)

- ☐ First used _____years ago
- ☐ Use Currently

Strength ☐ 15-20 ☐ 20-30 ☐ 30-40

Period of past use_____ ☐ months ☐ years

- ☐ Never Used Compression Stockings

Do you have Symptom Relief With:

Elevation ☐ Yes ☐ No ☐ Partial

Medication ☐ Yes ☐ No ☐ Partial

I have attempted weight reduction:

☐ Yes ☐ No ☐ Not an Issue

Weight reduction helped? ☐ Yes ☐ No

I exercise:

☐

☐ Daily _____ times per week

☐ Weekly ☐ No regular exercise

Name_____

DOB_____

Symptoms Interfere with my Daily Life:

☐ Work ☐ Air Travel

☐ Leisure Activity ☐ Long Car Travel

☐ Routine Activity ☐ None whatsoever

IMPORTANT: Give examples of above

_____

_____

_____

_____

III) General Medical History

Current Medications ☐ None

_____

_____

_____

_____

_____

_____

_____

Medication Allergies: ☐ None

_____

reaction_____

_____

reaction_____

_____reaction_____

_____

_____reaction_____

_____ ☐

Any prior reaction to: None

☐ Lidocaine ☐ Novocaine

☐ Iodine ☐ Latex

Type of reaction:

_____

_____

_____

_____

Past or Current Medical Conditions:

☐ No other problems

_____

_____

_____

_____

_____

Surgeries?
Date?

_____

_____

_____

_____

_____

_____

Family members with varicose veins

☐ Mother ☐ Father ☐ Brother / Sister

Smoking ☐ Never ☐ Quit # years ago

_____

☐ Yes # of packs per day

_____

Alcohol ☐ never ☐ social ☐ Moderate

ROS (circle all that apply)

Migraines Sinusitis Swollen glands

Asthma Emphysema Bronchitis

Chest pain Irregular Heartbeat

Joint pain Muscle Weakness

High BP Bruising Rash

Skin lesions Nausea Vomiting

UTI's Urine Frequency

Anxiety Depression Neuropathy

Diabetes Thyroid disorder

Blood clots DVT Embolism

Height_____
Weight_____

When was your last: (Date)

Colonoscopy_____

Mammogram_____

Flu Shot_____

Pneumonia shot_____