ADVANCED MEDICAL IMAGING
VEIN CENTER

Health & Vascular History

Patient Information

Name: ____ Date: ______________________

Age: _____

How Did You Hear About Us?

Referring Physician:______________________________

Please check one:

- 5280
- Direct Mail
- Brochure
- Friend
- Advanced Medical Imaging Website
- Family Member
- Internet/Search Engine
- Health Club
- Health Magazine
- Other

Primary Care Information

Primary Care Physician: __________________________ Phone #: _____________________

Symptoms

Varicose/Spider veins have been present for ________ years.

Please check if you have:

- Red spider veins
- Skin discoloration below your knee
- Purple veins
- Ankle sores
- Purple vein network
- Abdominal veins
- Bulging veins
- Diagnosis of vein disease
- Flat bluish-green veins
- Other: _________________

Do your legs or ankles:

- Ache or hurt? Please Describe: _______________________________
- Swell? Please Describe: _______________________________
- Cramp? Please Describe: _______________________________
- Become restless? Please Describe: _______________________________
- Become tired/heavy? Please Describe: _______________________________
- Itch? Please Describe: _______________________________
- Other? Please Describe: _______________________________

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Medical History

Is there a history in your **family** of spider or varicose veins?
Describe which:

Mother ____________________
Father _____________________
Grandparents ______________
Siblings ________________
Aunt/Uncle ______________
Child _________________

Is there a history in your **family** of deep venous thrombosis, stroke or clotting disorders?
Describe which:

Mother ____________________
Father _____________________
Grandparents _______________
Siblings ________________
Aunt/Uncle ______________
Child _________________

Do **you** have a history of:

Anemia
Ankle Skin changes
Atherosclerosis
Bleeding/Blood disorder
Chest pain discomfort
Constipation
Crohn's disease, IBS
Mitral valve prolapse
Deep Vein Thrombosis/clot
Diabetes; Insulin dependent
Easy bruising
HIV
Heart disease
Hepatitis
Hypertension
Kidney disease
Leg ulcers
Liver Disease
Lupus
Migraine Headaches
Migraine with Aura
Pulmonary embolus
Rupture of a vein
Superficial Thrombophlebitis
Trauma to your legs
Other __________________

Have you ever been tested for or found positive for a PFO (Patent Foramen Ovale) or ASD (Atrial Septal Defect)? ______Yes ______No

Current Medical Information

Do you have allergies or sensitivities to medicines or tape? List all: ______________________

Are you being treated for any illnesses or conditions? _________ If so, what illness: _________

____

Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

____

Women:

Are you pregnant or planning to be soon? _______ Are you currently breast-feeding? _______

Number of pregnancies thus far? _______

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Vascular History

Please check any methods you have used to relieve your leg discomfort:

No Discomfort	Warms Soaks
Leg Elevation	Cold Packs
Exercise	Pain Meds
Flexion/Extension of your feet	Aspirin
Walking	Tylenol
Support Hose	Ibuprofen
Wraps	Other Methods

What is the **earliest** date that you started taking pain medications for leg problems (aspirin, Tylenol, Ibuprofen, other pain meds) and what was the outcome? ________________________

____

What is the **earliest** date that you wore medical support hose for your leg problems? _________

____

How have your daily activities been affected or limited by your leg problems? _______________

____

Are you on your feet for long periods? ________ In what capacity? _______________________

____

Does walking/exercise relieve your discomfort or make it worse? _________________________

Have you been treated for your veins before? ____

By whom? ______________________________ When? _______________________________

What method?

Cosmetic Injections	Ultrasound-Guided Injections
Stripping	Radiofrequency Closure
Ambulatory Phlebectomy	Laser Catheter Ablation
Ligation	Laser for Spider Veins
Other __________________	

What have your results been? ____

What about your legs would you most like to correct? _________________________________

____

Consent To Photograph

I, ________________________________, give permission to Advanced Medical Imaging Vein Center staff to take photographs during my evaluation on ______________. These photographs are used to evaluate and guide treatments and may be used for research or professional case presentations.

______________________________________ ______________________________

Patient Date

______________________________________ ______________________________

Staff Signature Date