Albuquerque Vein & Laser Institute

Albuquerque Vein & Laser Institute New Patient Intake Form

Name: _____ Date of Birth: _____

Vein History

Please ☑ next to the symptoms that apply to you:

☐ Aching leg ☐ Burning ☐ Tiredness
☐ Dull Pain ☐ Heaviness ☐Itching ☐ Leg Ulcers
☐ Restless Legs ☐ Sharp Pain ☐ Swelling ☐Throbbing
☐Other: _____

Do you have (now or in the past): ☐ Varicose veins ☐Spider veins ☐Skin ulcer

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort? _____

Is the problem getting worse? ☐Yes ☐No

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg(s), (*Circle)* Right Leg / Left Leg

Is the leg discomfort aggravated by: ☐Standing ☐Walking ☐Exercise ☐Other_____

Is the leg discomfort relieved by: ☐Walking ☐Leg Elevation ☐Medication ☐Other_____

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long?_____

Do you have a family history of vein problems? ☐ No ☐ Yes, What family member? _____

Is there a family history of blood clots in the legs or lungs? ☐ No ☐ Yes, What family member? _____

Do you take any medications for pain in your legs? ☐ No ☐ Yes, Which? _____

Have you ever had any of the following:

Skin ulcer on your leg?	☐No	☐Yes, When _____
Previous vein surgery?	☐No	☐Yes, When _____
Bleeding from varicose veins?	☐No	☐Yes, When _____
Clotting disorder?	☐No	☐Yes, When _____
Deep vein blood clot (DVT)?	☐No	☐Yes, When _____
Pulmonary embolus (blood clot to lungs)?	☐No	☐Yes, When _____
Phlebitis (clot in surface vein of leg)?	☐No	☐Yes, When _____
Sclerotherapy?	☐No	☐Yes, When _____
Trauma/injury to your legs?	☐No	☐Yes, When _____
HIV/Hepatitis?	☐No	☐Yes, When _____
IV drug use?	☐No	☐Yes, When _____

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Habits

Do you drink alcoholic beverages? ☐No ☐Yes (*#/week* _____)

Do you now or have you ever used tobacco? ☐No ☐Yes *(Packs/week* _____)

Quit Date, if applicable _____

Do you exercise regularly? ☐No ☐Yes (*#of days / week* _____)

Medications (please list all prescriptions, over-the-counter medications, and herbs/supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (please list any allergies to medications, latex, etc…)

_____ _____ _____

Past Medical History

Condition	YES	NO
Thyroid abnormalities	☐	☐
Asthma	☐	☐
COPD	☐	☐
Atrial fibrillation	☐	☐
Murmur	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
High cholesterol	☐	☐
Glaucoma	☐	☐
Migraine headaches	☐	☐
Depression	☐	☐

	YES	NO
Anemia	☐	☐
Angina (chest pain)	☐	☐
Arthritis	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Acid reflux (GERD)	☐	☐
Spinal stenosis	☐	☐
Stroke/seizures/TIA	☐	☐
Osteoporosis/Osteopenia	☐	☐

Other:

_____

_____

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Past Surgical History (Please list surgeries & dates):

_____ _____

_____ _____

_____ _____

Females only:

Are you pregnant? ☐No ☐Yes Number of Pregnancies _____Number of Deliveries _____Miscarriages_____

Height: _____ft _____ inches **Weight**: _____ lbs

Review of Systems: Have you recently had any of the following symptoms?

General:
Weight changes ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes

Eye:
Decreased vision ☐ No ☐ Yes
Blurred vision ☐ No ☐ Yes

Neurological:
Weakness ☐ No ☐ Yes
Seizure ☐ No ☐ Yes
Headache ☐ No ☐ Yes

Cardiac:
Chest pain ☐ No ☐ Yes
Palpitations ☐ No ☐ Yes
Swelling ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes

Urinary:
Painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Prostate problems ☐ No ☐ Yes

Mental:
Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Confusion ☐ No ☐ Yes

Hematologic:
Easy bruising ☐ No ☐ Yes
Abnormal blood clotting ☐ No ☐ Yes

Skin:
Rash ☐ No ☐ Yes
Dry skin ☐ No ☐ Yes

Ears/Nose/Throat:
Sore throat ☐ No ☐ Yes
Nosebleeds ☐ No ☐ Yes
Ringing in ears ☐ No ☐ Yes

GI:
Indigestion ☐ No ☐ Yes
Vomiting blood ☐ No ☐ Yes
Bloody stools ☐ No ☐ Yes
Abdominal pain ☐ No ☐ Yes

Respiratory:
Cough ☐ No ☐ Yes
Wheezing ☐ No ☐ Yes
Coughing blood ☐ No ☐ Yes

Musculoskeletal:
Bone/joint deformity ☐ No ☐ Yes
Joint swelling ☐ No ☐ Yes
Back pain ☐ No ☐ Yes

Endocrine:
Excessive thirst ☐ No ☐ Yes
Thyroid problems ☐ No ☐ Yes

Gynecologic (females only):
Irregular periods ☐ No ☐ Yes
Breast problems ☐ No ☐ Yes