MINNESOTA VEIN CENTER

400 Village Center Drive, Suite 800, North Oaks, MN 55127 • *phone* 651-765-VEIN (8346) • *web* www.mnveincenter.com

Patient Name: ______________________________ MR#: __________ Date: ____________

What is the reason for your visit today? ______________________________

How long have you had this problem? ________ Years ________ Months

Please check which symptoms you currently have or have had:

- ☐ Leg Pain
- ☐ Itching
- ☐ Leg Cramps
- ☐ Heaviness
- ☐ Tiredness/fatigue
- ☐ Aching/Throbbing
- ☐ Open Sore/Ulcer
- ☐ None
- ☐ Tenderness
- ☐ Burning
- ☐ Red Warm Areas
- ☐ Other: ____________________
- ☐ Ankle Swelling
- ☐ Stinging
- ☐ Restless Legs

How would you rate your symptoms? (circle one)

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Excruciating

Have your symptoms/veins gotten worse in recent months?

☐ Yes ☐ No

Describe: ______________________________

Are your symptoms worse with any of the following?

Prolonged sitting/standing ☐ Yes ☐ No At home?________ At work? ____________

Hot Baths/Heat ☐ Yes ☐ No

Menstrual Cycle ☐ Yes ☐ No

Which of the following have you tried to treat your leg symptoms:

1. Medication (i.e. Advil, Motrin) ☐ Yes ☐ No

   If yes, name and strength: ______________________________ How often? ____________

2. Elevation of legs ☐ Yes ☐ No

   If yes, how long? ______________________________ How often? ____________

3. Wear support hose

   ☐ Yes ☐ No

   If yes, what type? ______________________________ For how long? ____________

4. Avoidance of any activities which make symptoms worse (i.e. hot baths, saunas)

   ☐ Yes ☐ No

   If yes, what? ______________________________

5. Exercise

   ☐ Yes ☐ No

   If yes, what type? ______________________________ How often? ____________

6. Weight reduction

   ☐ Yes ☐ No

   If yes, how many pounds (lbs)? ____________

How do your symptoms alter your daily activities at work/home? ______________________________

How do your symptoms alter your leisure activities such as sports, hobbies, social life, family?

____

Have you seen any physician in the past for your veins?

☐ Yes ☐ No

If yes, explain: ______________________________

Can we contact the doctor(s) for your records?

☐ Yes* ☐ No

*(i.e. prescription for compression hose, office notes from PCP, OB/GYN, surgeon, etc.)

Physician Signature: ______________________________ Date: ____________