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

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: ____________