Advanced Vein Center
210 Western Ave., South Portland, Maine 04106

Patient Name: _____ **DOB:** _____

Current Height: _____ **Weight:** _____ **Accompanied by: Name/Relation**_____

Chief Complaint: _____

Location of complaint: Right Left Bilaterally Leg Calf

□ **Pain** □ **Cramping** □ **Aching** □ **Heaviness** □ **Swelling** □ **Restlessness** □ **Fatigue**

Symptoms Improve With:

□ **Compression** □ **Rest** □ **NSAIDS**

Symptoms Worsen With:

□ **Prolonged standing** □ **Other**

	Y	N		Y	N		Y	N
Abnormal clotting			Difficulty swallowing			**URINARY:**		
Hypertension			Vitamin D deficiency			Venereal Disease		
Heart Failure			Abnormal bleeding			Bladder Infection		
Heart Attack			Anemia			Kidney Disease		
Chest pain						Freq. urination		
Broken bones			**EARS / NOSE / THROAT:**			Blood in urine		
Shortness of breath			Glaucoma			Kidney infec/stones		
Swelling in ankles			Deafness			Hepatitis		
Emphysema			Ringing in ears					
Varicose Veins			Nose bleeds			**ENDOCRINE:**		
DVT (blood clot)			Hearing loss			Diabetes		
Factor V Leiden			Vision loss			Excessive thirst		
Asthma			Cataracts			Lupus		
Hx of trauma to leg(s)						Thyroid		
			GASTRO:			Gout		
			Weight loss			Rheumatism		
NEUROLOGICAL:			Weight gain			Arthritis/ Joint pain		
Headache			Chronic heartburn			Temp. Sensitivity		
Weakness						Nerve disorder		
Stroke			**GYN:**			Swelling of hand/feet		
Traumatic brain inj.			Pelvic pain			Thyroid Disease		
Seizures / Epilepsy			Vulvar/Buttocks varicosities			Hormone Replacement		
Depression			Painful intercourse					

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Patient Name:_____ **Date of Birth:**_____

Surgical History or Hospitalizations

Date	Type of Surgery	Reason/ Complications

OB History

# Pregnancies:	# of Children:	Complications / Miscarriages:

Family History – Please specify which relative

	Yes	No		Yes	No
Varicose Veins			Clotting Disorder		
Clotting Disorder			Alcoholism		
Blood clot (legs/ lungs) DVT/ PE			Cancer – type:		
Coronary Artery Disease			High Blood Pressure		
CVA			Diabetes		

Father Living Yes / No	Mother Living Yes / No	Siblings- Living #	Sisters #	Brothers #

Social History

	Yes	No		Yes	No
Do you Smoke?			Do you stand / lay down for long periods of times		
Do you consume alcohol / amt. weekly			What is your current occupation?		

Do you consume "green tea" in any form (liquid, supplement, powder)? Yes No

Have you traveled outside of the Country in the last 21 days? Yes No

ALLERGIES: ___Latex ___Other:_____

MEDICATIONS:_____

_____

We are able to automatically import your medical history from a third party (i.e. pharmacies). By signing below, you give Advanced Vein Center permission to transfer your medication history.

Current Pharmacy:_____

I, Myself, have filled our this health questionnaire completely and I have notified the office of all of medical problems.

Patient:_____ **Date:**_____