Vein Treatment Specialists, PC
Dr. Bob Dupper, MD, Phlebologist.
Specializing in outpatient treatment of varicose vein disease.

Patient History

Date _____ / ______ /__________ Patient Name ___________________________________

Soc Sec # _______ - _____ - ___________ Age _______ Date of Birth ____/_____/________

Referred by ____

Describe your reasons for seeing us today: ____

____

____

Have you had prior vein treatment? ☐ Yes ☐ No When? ___________________________

What were the prior treatments?

☐ No Prior Vein Treatment ☐ Conservative Therapy ☐ Ligation ☐ Surgical Stripping
☐ Ambulatory Phlebectomy ☐ Injection Sclerotherapy ☐ SEPS ☐ Laser for spider veins
☐ VNUS or radiofrequency closure ☐ EVLA or laser for large varicose veins

☐ Other: ____

Have you personally ever been treated for the following?

Leg phlebitis (vein inflammation)	☐ Yes	☐ No	Hospitalization?	☐ Yes	☐ No
Leg DVT (deep vein blood clot)	☐ Yes	☐ No	Hospitalization?	☐ Yes	☐ No
Leg ulcer (venous ulceration)	☐ Yes	☐ No	Hospitalization?	☐ Yes	☐ No
Prior leg fracture or significant trauma	☐ Yes	☐ No	Hospitalization?	☐ Yes	☐ No
Pulmonary embolism (blood clot in lung)	☐ Yes	☐ No	Hospitalization?	☐ Yes	☐ No

When did your vein problem start?

Age _____________ ☐ Before pregnancy ☐ During pregnancy ☐ After pregnancy
☐ After traumatic injury ☐ After estrogen therapy ☐ Other ____________________

What are the ages of your children in years? ____

Are you forming new veins? ☐ Yes ☐ No; Are your current veins getting bigger? ☐ Yes ☐ No

If you experience lower extremity pain, is the pain worsened by:

Extended periods in standing position?	☐ Yes	☐ No	Heat?	☐ Yes	☐ No
Menstrual periods?	☐ Yes	☐ No	Exercising and/or walking?	☐ Yes	☐ No

If your experience lower extremity pain, is the pain improved by:

Elevation of the legs?	☐ Yes	☐ No	Compression stockings?	☐ Yes	☐ No
Walking and/or exercising?	☐ Yes	☐ No	Medication you are taking?	☐ Yes	☐ No

Indicate the type(s) of discomfort you have experienced in your lower extremities:

Resting pain?	☐ Yes	☐ No	Night cramps	☐ Yes	☐ No
Resting cramps?	☐ Yes	☐ No	Heaviness in the legs?	☐ Yes	☐ No
Tiredness?	☐ Yes	☐ No	Burning sensation?	☐ Yes	☐ No
Numbness?	☐ Yes	☐ No	Restless Leg?	☐ Yes	☐ No
Fatigue?	☐ Yes	☐ No	Leg or ankle swelling?	☐ Yes	☐ No

Pain in specific areas?____________________

Do you have a family history of:

Varicose vein problems?	☐ Yes	☐ No	In whom? ___________________________
Phlebitis (vein inflammation)?	☐ Yes	☐ No	In whom? ___________________________
Deep venous thrombosis? (Blood clots)	☐ Yes	☐ No	In whom? ___________________________
Venous leg ulcers?	☐ Yes	☐ No	In whom? ___________________________

Have you personally had any of the following medical problems (If you don't know you probably have not had it.):

Diabetes?	☐ Yes	☐ No	Hypertension?	☐ Yes	☐ No
Seizure or convulsions?	☐ Yes	☐ No	Stroke?	☐ Yes	☐ No
Blood transfusions?	☐ Yes	☐ No	Fainting or dizzy spells?	☐ Yes	☐ No
Street drug usage?	☐ Yes	☐ No	Hives?	☐ Yes	☐ No
Arthritis?	☐ Yes	☐ No	Asthma?	☐ Yes	☐ No
Bleeding disorder?	☐ Yes	☐ No	Tobacco Smoking?	☐ Yes	☐ No
Easy bruisability?	☐ Yes	☐ No	Blood Infection?	☐ Yes	☐ No
Autoimmune disorder?	☐ Yes	☐ No	Hepatitis?	☐ Yes	☐ No
Blood clot in your legs?	☐ Yes	☐ No	Heart disease?	☐ Yes	☐ No
Pulmonary embolism (blood clot in your lung)?	☐ Yes	☐ No	Hemorrhage – bleeding from varicose veins?	☐ Yes	☐ No
COPD or emphysema?	☐ Yes	☐ No	Migraine headache?	☐ Yes	☐ No
Irregular Heart Rhythm?	☐ Yes	☐ No	Heart Murmur?	☐ Yes	☐ No
"Hole in your heart?"	☐ Yes	☐ No	HIV/AIDS?	☐ Yes	☐ No
Superficial Phlebitis or Thrombophlebitis?	☐ Yes	☐ No	Venous Stasis Ulcer?	☐ Yes	☐ No

Other medical problem (please explain): ____

Patient History

Prior Surgeries: ____

Do you personally have an allergy to any of the following? (please list)

- Medication allergies? ☐ No ☐ Yes ______________________
- Food allergies? ☐ No ☐ Yes ______________________
- Latex allergy? ☐ No ☐ Yes
- Adhesive tape allergy or sensitivity? ☐ No ☐ Yes

Does your work require a prolonged standing or sitting position? ☐ Yes ☐ No

Have you ever worn support stockings on your legs? ☐ Yes ☐ No

Do you currently wear support stockings on your legs? ______________________

Indicate which of the following medications you are taking?

Aspirin or blood thinners?	☐ Yes	☐ No	Anticoagulants?	☐ Yes	☐ No
BCP's or hormones?	☐ Yes	☐ No	Chemotherapy?	☐ Yes	☐ No
Thyroid medication?	☐ Yes	☐ No	Prednisone or steroids?	☐ Yes	☐ No
Insulin?	☐ Yes	☐ No	Minocycline	☐ Yes	☐ No

Other meds? ____

Are you currently pregnant, trying to get pregnant, or planning a pregnancy? ☐ Yes ☐ No

Indicate the date of your last physical exam ______________________

______________________ ______________________

Patient Signature Date

Physician Notes: ____