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

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Number of Pregnancies: _____ Number of children: _____ Are you pregnant now? Y / N Date of Last Menstrual Period: _____

I am seeking treatment for: ( ) Spider Veins ( ) Varicose Veins Which I have had for _____ months/years

On a scale of 1 to 10, 10 being the worst, please rate your symptom(s), if applicable:

Symptoms	Degree of Complaint	Symptoms	Degree of Complaint
____Pain	1 2 3 4 5 6 7 8 9 10	____Edema	1 2 3 4 5 6 7 8 9 10
____Itching	1 2 3 4 5 6 7 8 9 10	____Thrombosis/Phlebitis	1 2 3 4 5 6 7 8 9 10
____Heaviness	1 2 3 4 5 6 7 8 9 10	____Spon. Hemorrhage	1 2 3 4 5 6 7 8 9 10
____Aching	1 2 3 4 5 6 7 8 9 10	____Redness/Discoloration	1 2 3 4 5 6 7 8 9 10
____Cramping	1 2 3 4 5 6 7 8 9 10	____Ulceration	1 2 3 4 5 6 7 8 9 10
____Burning/Stinging	1 2 3 4 5 6 7 8 9 10	____Other _____	1 2 3 4 5 6 7 8 9 10

Frequency of symptoms: ____ Daily ____Weekly ____Monthly

Precipitating Factors:

____**None**
____Standing
____Sitting
____Premenstrual
____Night
____Exercise/Walking
____Pregnancy
____Other _____

Relieving Factors:

____**None**
____Exercise
____Elevation
____Coolness
____Medications
____Compression Garment ____more than 6 months
____less than 6 months
____Weight reduction
____Other _____

-Do your Activities of Daily Living (ADLs) require prolonged periods of standing or sitting? Y / N
-If yes, how many times per day do you have to take a break due to aching, burning, cramping, pain or swelling in the lower extremities?
(please circle one) Never One time per day 2-3 times per day 4+ per times daily

-Do you take over-the-counter or prescription medications for aching, burning, cramping, pain or swelling of the lower extremities? Y / N
-If yes, what medication & dose? _____
-If yes, how many days in a two week period of time did you take medications?
(please circle one) 0-2 days 3-4 days 5-6 days 7+days

How do your symptoms affect your Activities of Daily Living? _____
_____

Previous Treatment(s)			Date	Previous Treatment(s)			Date
____ *None*			_____	____ *Sclerotherapy*	*Left*	*Right*	_____
____ *Ligation*	*Left*	*Right*	_____	____ *Laser*	*Left*	*Right*	_____
____ *Stripping/ELT*	*Left*	*Right*	_____	____ *Phlebectomy*	*Left*	*Right*	_____

FAMILY HISTORY

Has anyone in your family ever had varicose veins? Y / N If yes, who? _____

Does anyone in your family have a history of blood clots? Y / N If yes, who? _____

Please describe any aspect of your family history that you feel is pertinent to your health: (cancer, diabetes, heart disease, obesity, etc.)

_____
_____

◊ I decline to authorize the Laser and Vein Center of North Jersey to use my pre & post procedure anonymous photos for any marketing or promotional purposes