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## History and Physical

**Patient Name:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  M  F

**Referred by:** \_\_\_\_\_

**Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**PCP:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Occupation** \_\_\_\_\_

*Please answer each question by checking yes or no*

**Past History:**

	Yes	No
Stroke/TIA	___	___
Heart Disease	___	___
1. Heart Attack	___	___
2. A Fib Angina	___	___
3. Heart Surgery	___	___
4. Angioplasty	___	___
Pacemaker/Defibrillator	___	___
High Blood Pressure	___	___
HIV/AIDS	___	___
Lung Disease	___	___
Kidney Disease	___	___
Diabetes	___	___
High Cholesterol	___	___
Hepatitis A B C (circle)	___	___
Asthma COPD	___	___
Surgical history _____	___	___
Cancer _____	___	___
Anemia/Low Blood Count	___	___

Have you ever been treated for any of the following?

	Yes	No	Left	Right
a. Phlebitis	___	___	___	___
b. Leg Ulcerations	___	___	___	___
c. Blood clots/ Pulmonary Embolism	___	___	___	___
d. Leg fracture	___	___	___	___

**Social History:**

	Yes	No
Married	___	___
Current Tobacco Use	___	___
Years of use	___	___
Packs per day	___	___

**Family History:**

	Yes	No
Stroke	___	___
Diabetes	___	___
Heart Disease	___	___
Cancer	___	___
Varicose Veins	___	___
Vascular Disease	___	___
Aneurysm	___	___

Have you ever worn support stocking \_\_\_\_\_  
 What Kind? \_\_\_\_\_ Compression \_\_\_\_\_  
 How Often? \_\_\_\_\_  
 Do you have leg pain/discomfort \_\_\_\_\_  
 Does the discomfort interfere with normal daily activities? \_\_\_\_\_  
 Do the stockings relieve leg discomfort? \_\_\_\_\_  
 Do the stockings cause leg discomfort? \_\_\_\_\_  
 Have you used analgesics for pain? \_\_\_\_\_  
 If yes, how long \_\_\_\_\_

**Medications:**

**Please List Current Medications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies: None** (circle if none)

	Yes	No
Latex	___	___
Medication Allergies:	___	___
Please List: _____		

**Current Complaint:**

Are you here for: Cosmetic Purposes \_\_\_ Medical Reasons \_\_\_

1. Indicate which of the following problems you have experienced:

	Right	Left	How many years
a. Discomfort in your			
1) Thigh	___	___	___
2) Groin	___	___	___
3) Calf	___	___	___
4) Leg	___	___	___
5) Foot	___	___	___
b. Swelling of the legs	___	___	___

3. When did your varicose veins occur? Age \_\_\_\_\_

	Yes	No
a. Before pregnancy	___	___
b. During pregnancy	___	___
c. After trauma	___	___
d. After Birth Control/Estrogen Therapy	___	___
e. Are you developing new veins	___	___
f. Are your veins getting bigger	___	___



5. If you have experienced discomfort in your legs

- |                                    |     |     |                                    |     |     |
|------------------------------------|-----|-----|------------------------------------|-----|-----|
| a. Indicate the type of discomfort | Yes | No  | b. Is the discomfort made worse by | Yes | No  |
| 1) Resting Discomfort              | ___ | ___ | 1) Extended periods of standing    | ___ | ___ |
| 2) Resting Cramps                  | ___ | ___ | 2) Heat                            | ___ | ___ |
| 3) Night Cramps                    | ___ | ___ | 3) Physical activity or walking    | ___ | ___ |
| 4) Tiredness                       | ___ | ___ | 4) Medications                     | ___ | ___ |
| 5) Heaviness in the legs           | ___ | ___ | 5) Menstruation                    | ___ | ___ |
| 6) Numbness                        | ___ | ___ | 6) Intercourse                     | ___ | ___ |
| 7) Burning                         | ___ | ___ |                                    |     |     |
| 8) Pain in specific area           | ___ | ___ |                                    |     |     |
| Area _____                         |     |     |                                    |     |     |
| c. Is the discomfort relieved by   | Yes | No  |                                    |     |     |
| 1) Elevation                       | ___ | ___ |                                    |     |     |
| 2) Stockings                       | ___ | ___ |                                    |     |     |
| 3) Activity / Walking              | ___ | ___ |                                    |     |     |

6. Have you ever been treated for this problem? Yes \_\_\_ No \_\_\_  
 \_\_\_

By whom? \_\_\_\_\_ When? \_\_\_\_\_

7. Treatment method used? Injection \_\_\_ Electrocautery \_\_\_ Stockings \_\_\_ Surgery \_\_\_ Laser \_\_\_

8. If you have not been referred by your primary care physician, would you like copies of your reports forwarded to him/her? Yes \_\_\_ No \_\_\_

**Review of Systems:**  
*Check all that apply*

**Constitution:**

- \_\_\_ Fever
- \_\_\_ Chills
- \_\_\_ Weight Loss
- \_\_\_ Night Sweats

**Neuro/Psych:**

- \_\_\_ Headache
- \_\_\_ Passed Out
- \_\_\_ Dizziness/Lightheadedness
- \_\_\_ Numbness/tingling
- \_\_\_ Weakness
- \_\_\_ Difficulty swallowing
- \_\_\_ Difficulty speaking
- \_\_\_ Temporary blindness

**HEENT:**

- \_\_\_ Runny nose
- \_\_\_ Sore throat
- \_\_\_ Difficulty hearing
- \_\_\_ Head injury

**MSK:**

- \_\_\_ Fractures
- \_\_\_ Arthritis
- \_\_\_ Neck pain
- \_\_\_ Muscle pain
- \_\_\_ Gout

**Respiratory:**

- \_\_\_ Difficulty Breathing
- \_\_\_ Coughing Blood
- \_\_\_ Chronic Cough
- \_\_\_ Wheezing

**Cardiovascular:**

- \_\_\_ Chest pain/discomfort (circle)
- \_\_\_ Pressure Tightness Squeezing
- \_\_\_ Irregular heartbeat/palpitations
- \_\_\_ Shortness of breathe
- \_\_\_ Leg/feet swelling

**Endocrine:**

- \_\_\_ Excessive thirst
- \_\_\_ Hair Loss
- \_\_\_ Excessive Sweating

**Vascular:**

- \_\_\_ Pain in legs while walking
- \_\_\_ Pain in legs while at rest
- \_\_\_ Blood clots
- \_\_\_ Varicose veins

**GI:**

- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Blood in Stools
- \_\_\_ Nausea/Vomiting
- \_\_\_ Heartburn/reflux
- \_\_\_ Pain after meals
- \_\_\_ Gallstones

**GU:**

- \_\_\_ Blood in urine
- \_\_\_ Painful urination
- \_\_\_ Excessive urination

**Skin:**

- \_\_\_ Rash
- \_\_\_ Ulcers

\_\_\_\_\_  
 Radia Physician Signature