MORRISON
VEIN INSTITUTE

Better Care. Better Results.

CONFIDENTIAL HEALTH & VASCULAR HISTORY: MEN

PATIENT INFORMATION

Name:____Date:________________

Age:____ Sex:_____ Years with varicose / spider veins?______

HOW DID YOU HEAR ABOUT US?

Referring Doctor:____

Please check one:

Magazines
- ❑ AZ Foothills Magazine
- ❑ AZ Magazine
- ❑ Phoenix Magazine
- ❑ Phx Home & Garden Magazine

TV
- ❑ Channel 8 PBS
- ❑ Channel 12 NBC
- ❑ Channel 15 ABC

Radio
- ❑ KBAQ 89.5 FM
- ❑ KEZ 99.9 FM
- ❑ KJZZ 91.5 FM
- ❑ KTAR 92.3 FM
- ❑ KNIX 102.5 FM
- ❑ KOY 1230 AM

Newspapers
- ❑ AZ Republic
- ❑ Phoenix Business Journal

Miscellaneous
- ❑ Yellow Pages
- ❑ Friend/MVI Patient

Name:________________
- ❑ Internet
- ❑ www.veindirectory.org
- ❑ Chamber of Commerce
- ❑ Other

____

PRIMARY CARE INFORMATION

Primary Care Physician: ______________________ Phone Number: ____________________________

SYMPTOMS

Please check if you have:
- ❑ Red spider veins
- ❑ Skin discoloration below your knee
- ❑ Purple veins
- ❑ Purple vein network
- ❑ Abdominal veins
- ❑ Bulging veins
- ❑ Flat bluish-green veins
- ❑ Diagnosis of vein disease
- ❑ Leg ulcer
- ❑ Other:__________________________

Do your legs or ankles:
- ❑ Ache or hurt? Please describe________________________________
- ❑ Swell? Please describe________________________________
- ❑ Cramp? Please describe________________________________
- ❑ Become restless? Please describe________________________________
- ❑ Become tired / heavy? Please describe________________________________
- ❑ Itch? Please describe ________________________________
- ❑ Other? Please describe________________________________

MEDICAL HISTORY

Is there a history in your **FAMILY** of spider or varicose veins?
Describe which:

- ❑ Mother_________________________
- ❑ Father_________________________
- ❑ Grandparents____________________
- ❑ Siblings________________________
- ❑ Aunt/Uncle_____________________
- ❑ Child__________________________

Is there a history in your **FAMILY** of deep venous thrombosis, stroke or clotting disorders?
Describe which:

- ❑ Mother_________________________
- ❑ Father_________________________
- ❑ Grandparents___________________
- ❑ Siblings________________________
- ❑ Aunt/Uncle_____________________
- ❑ Child__________________________

Do **YOU** have a history of :

- ❑ Anemia
- ❑ Ankle skin changes
- ❑ Atherosclerosis
- ❑ Bleeding/blood disorder
- ❑ Chest pain discomfort
- ❑ Constipation
- ❑ Crohn's disease, IBS
- ❑ Deep Vein Thrombosis/clot
- ❑ Diabetes, insulin dependent
- ❑ Easy bruising
- ❑ Erectile difficulty/dysfunction
- ❑ Heart disease
- ❑ Hepatitis
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Leg ulcers
- ❑ Liver disease
- ❑ Lupus
- ❑ Migraine headaches
- ❑ Migraine with Aura
- ❑ Mitral valve prolapse
- ❑ Pulmonary embolus
- ❑ Rupture of a vein
- ❑ Superficial thrombophlebitis
- ❑ Trauma to your legs
- ❑ Other______________________
  ____
  ____

Have you ever been tested for or found positive for a PFO (Patent Foramen Ovale) or ASD (Atrial Septal Defect)? ______Yes ______No

CURRENT MEDICAL INFORMATION

Do you have allergies or sensitivities to medicines or tape? List all: ________________________
____

Are you being treated for any illnesses or conditions? ______ If so, what illness: _____________

____

Please list all medicines that you take (prescription, non-prescription, vitamins, and herbal):____
____
____

VASCULAR HISTORY

Please check any methods you have used to relieve your leg discomfort:

- ❑ No discomfort
- ❑ Leg elevation
- ❑ Exercise
- ❑ Flexion/extension of your feet
- ❑ Walking
- ❑ Support hose
- ❑ Wraps
- ❑ Warm soaks
- ❑ Cold packs
- ❑ Pain medications
- ❑ Aspirin
- ❑ Tylenol
- ❑ Ibuprofen
- ❑ Other methods:________________

What is the **earliest** date that you started taking pain medications for leg problems (aspirin, Tylenol, Ibuprofen, other pain meds) and what was the outcome?__________________________

____

____

*What is the **earliest** date that you wore medical support hose for your leg problems? _________

____

Some insurance plans require that compression hose be worn 6 months prior to request for treatment.

How have your daily activities been affected or limited by your leg problems? ______________

____

Are you on your feet for long periods? _______ In what capacity? ________________________

____

Does walking/exercise relieve your discomfort or make it worse? ________________________

Have you been treated for your veins before? ______________

By whom? _______________________ When? _____________________________

What method?

- ❑ Cosmetic injections
- ❑ Stripping
- ❑ Ambulatory phlebectomy
- ❑ Ligation
- ❑ Other_________________________
- ❑ Ultrasound-guided injections
- ❑ Radiofrequency closure
- ❑ Laser catheter ablation
- ❑ Laser for spider veins

What have your results been? ____

____

What about your legs would you now most like to correct? ______________________________

____