LAFAYETTE
Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

LRVLC Patient Questionnaire

Date:_____

Patient DOB Age Sex

Height Weight Ethnicity Race

Referral Source: Physician Name or Other

In your own words, please describe the reason for your visit today: _____

Symptom	R	L			R	L
Pain/Aching				Bleeding		
Swelling				Blood Clot Concerns		
Leg Cramping				Cosmetic Concerns		
Heaviness				Leg Injury/Ulcer		
Restlessness						

When did you first begin to notice the veins? _____
Duration: Weeks/Months/Years

Which leg is affected? ☐ Right ☐ Left ☐ Both

Which leg is the worst/ most problematic to you? ☐ Right ☐ Left ☐ Both

What time of the day are your symptoms most noticeable:

Constant			Early	
Upon Waking			Late Evening	
Late Morning			Throughout the night	
Early Morning				

LAFAYETTE
Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

Aggravating Factors: Relieving Factors:

Walking			Elevation	
Elevation			Walking	
Sitting/Standing			Compression	
Prolonged Car Rides			Analgesics	

Do you find it difficult to sleep? ☐ Yes ☐ No

Conservative Management: Which of the following have you tried to help with your symptoms over the past year? (Please circle)

. . .tried **support stocking** to relieve your vein problems without success?	Yes	No		. . .had to take time off work because of your vein problems?	Yes	No
. . .tried **exercising** regularly because of your vein problems?	Yes	No		. . .had recent **weight loss**	Yes	No
. . .had to change jobs because of your vein problems?	Yes	No		. . .had to elevate legs because of your vein problems?	Yes	No
. . .had to take **pain medicine** because of your vein problems?	Yes	No		. . .had to limit your activities and lifestyle because of your vein problems?	Yes	No

Other: _____

Complications of Venous Stasis:

☐ I have had a leg ulcer ☐ I have had a blood clot in my leg or other major organ

☐ I have suffered bleeding from a vein ☐ Minor wounds on my legs take longer to heal than expected

☐ I have previously been evaluated for my veins

Prior Vein Treatment for Medical of Cosmetic Purposes: Did this treatment Provide relief? Please check Yes or No

	Yes	No		Yes	No
☐ Surgical Stripping	☐	☐	☐ Sclerotherapy	☐	☐
☐ Thermal Ablation	☐	☐	☐ Laser or pulsed light treatment	☐	

LAFAYETTE
Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

Please indicate if you have any of the following conditions by circling Yes or No:

Diabetes	Yes	No		Seizures	Yes	No
Heart Disease	Yes	No		Renal Failure	Yes	No
Lung Disease	Yes	No		Hepatitis	Yes	No
Hypertension	Yes	No		HIV Infection	Yes	No
Arthritis	Yes	No		Fainting	Yes	No
Cancer	Yes	No		Tobacco Use	Yes	No

Other Medical Conditions:

_____

Current Medications:_____

Please indicate (by circling Yes or No) if you currently (or recently) were on any of the following:

Coumadin	Yes	No		Topical skin medications	Yes	No
Plavix	Yes	No		Antibiotics	Yes	No
Daily Aspirin	Yes	No		Steroids	Yes	No

Are you allergic to anything? ☐ Yes ☐ No
If yes, please list any and all allergies:

Past Surgical History:

☐ No Previous Surgeries or Hospitalizations

☐ Hip Replacement Surgery

_____

☐ KneeReplacement_____

_

☐ Spinal Surgery_____

☐ Ankle Fusion Surgery_____

☐ Gall Bladder Surgery_____

☐Hysterectomy_____

___

☐ Appendectomy_____

LAFAYETTE
Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

☐ Bariatric Surgery_____

Other Surgical History:

_____

For Women Only: Please indicate if Yes or No if you are . . .

I am currently nursing (breast feeding)	Yes	No		I am currently pregnant or think I might be	Yes	No
Pregnancy was more difficult because of your vein problems	Yes	No		I notice my leg symptoms at the time of my period	Yes	No
I have been diagnosed with pelvic congestion syndrome	Yes	No		I am on Hormone Replacement Therapy (HRT)	Yes	No
I am taking oral contraceptives	Yes	No		I am planning on starting hormone replacement therapy	Yes	No

Number of pregnancies: _____ Number of deliveries: _____

Social History: Yes No

Alcohol Consumption: ☐ ☐

_____

Tobacco Consumption: ☐ ☐

_____

Occupation: ☐ ☐ _____

Time Spent Walking Each Day (hrs)

_____

What do you do for fun when you're not having your veins evaluated? _____

Family History: Please indicate if any of the following conditions were present in your immediate family members:

☐ No known significant family history of vein disease, blood clots, or leg ulcers.

Varicose Veins?	Yes	No		Phlebitis?	Yes	No
Venous Ulcers?	Yes	No		A history of Vein Surgery?	Yes	No
Deep Vein Thrombosis?	Yes	No		Blood Clots?	Yes	No

LAFAYETTE
Regional Vein & Laser Center
A UNITY HEALTHCARE PARTNER

Review of Systems: Do you currently have any of the following?
If you check "Yes" for anything, explain on the line below the checkbox.

No	Yes	
		Constitutional: (Fevers, chills, recent unexplained loss of appetite or weight).
		Eyes:(Any recent unexplained change in visual acuity, double vision, excessive tearing or crusting).
		ENT: (No recent change in hearing ability, discharge, sore throat, dizziness or ringing in the ears).
		Cardiac: (No chest pain, shortness of breath, waking from sleep breathless, or cardiac meds).
		Respiratory: (No shortness of breath, productive cough, coughing up blood, or pain with breathing).
		Gastrointestinal: (No change in bowel habits, no black, red or bloody stools, vomiting or belly pain).
		Genitourinary: (No incontinence, frequent, urgent or painful urination. No waking at night to urinate).
		Musculoskeletal: (No change in walking ability or strength. No painful joints)
		Skin: (No problematic rashes or itching, no changes in skin color or sores that won't heal)
		Neurological: (No unexpected, unexplained numbness, tingling, or loss of memory or movement).
		Psychiatric: (No suicidal thoughts or hallucinations)