



Albuquerque Vein & Laser Institute New Patient Intake Form

Name: _____ Date of Birth: _____

Vein History

Please next to the symptoms that apply to you: Aching leg Burning Tiredness
 Dull Pain Heaviness Itching Leg Ulcers
 Restless Legs Sharp Pain Swelling Throbbing
 Other: _____

Do you have (now or in the past): Varicose veins Spider veins Skin ulcer

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort? _____

Is the problem getting worse? Yes No

Where are the veins you are seeking a medical opinion for located? Face Leg(s), (Circle) Right Leg / Left Leg

Is the leg discomfort aggravated by: Standing Walking Exercise Other _____

Is the leg discomfort relieved by: Walking Leg Elevation Medication Other _____

Have you ever worn prescription grade compression stockings? No Yes, When and for how long? _____

Do you have a family history of vein problems? No Yes, What family member? _____

Is there a family history of blood clots in the legs or lungs? No Yes, What family member? _____

Do you take any medications for pain in your legs? No Yes, Which? _____

Have you ever had any of the following:

- Skin ulcer on your leg? No Yes, When _____
- Previous vein surgery? No Yes, When _____
- Bleeding from varicose veins? No Yes, When _____
- Clotting disorder? No Yes, When _____
- Deep vein blood clot (DVT)? No Yes, When _____
- Pulmonary embolus (blood clot to lungs)? No Yes, When _____
- Phlebitis (clot in surface vein of leg)? No Yes, When _____
- Sclerotherapy? No Yes, When _____
- Trauma/injury to your legs? No Yes, When _____
- HIV/Hepatitis? No Yes, When _____
- IV drug use? No Yes, When _____

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Habits

Do you drink alcoholic beverages? No Yes (#/week _____)

Do you now or have you ever used tobacco? No Yes (Packs/week _____)

Quit Date, if applicable _____

Do you exercise regularly? No Yes (#of days / week _____)

Medications (please list all prescriptions, over-the-counter medications, and herbs/supplements)

Allergies (please list any allergies to medications, latex, etc...)

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Past Medical History

Condition	YES	NO		YES	NO
Thyroid abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Spinal stenosis	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/seizures/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Depression	<input type="checkbox"/>	<input type="checkbox"/>			

Other:

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Past Surgical History (Please list surgeries & dates):

_____	_____
_____	_____
_____	_____

Females only:

Are you pregnant? No Yes Number of Pregnancies _____ Number of Deliveries _____ Miscarriages _____

Height: _____ ft _____ inches **Weight:** _____ lbs

Review of Systems: Have you recently had any of the following symptoms?

General:

Weight changes No Yes
 Fatigue No Yes

Eye:

Decreased vision No Yes
 Blurred vision No Yes

Neurological:

Weakness No Yes
 Seizure No Yes
 Headache No Yes

Cardiac:

Chest pain No Yes
 Palpitations No Yes
 Swelling No Yes
 Shortness of breath No Yes

Urinary:

Painful urination No Yes
 Blood in urine No Yes
 Prostate problems No Yes

Mental:

Anxiety No Yes
 Depression No Yes
 Confusion No Yes

Hematologic:

Easy bruising No Yes
 Abnormal blood clotting No Yes

Skin:

Rash No Yes
 Dry skin No Yes

Ears/Nose/Throat:

Sore throat No Yes
 Nosebleeds No Yes
 Ringing in ears No Yes

GI:

Indigestion No Yes
 Vomiting blood No Yes
 Bloody stools No Yes
 Abdominal pain No Yes

Respiratory:

Cough No Yes
 Wheezing No Yes
 Coughing blood No Yes

Musculoskeletal:

Bone/joint deformity No Yes
 Joint swelling No Yes
 Back pain No Yes

Endocrine:

Excessive thirst No Yes
 Thyroid problems No Yes

Gynecologic (females only):

Irregular periods No Yes
 Breast problems No Yes