CHICAGO VEIN INSTITUTE
THE HEALTH & BEAUTY YOU DESERVE

Today's Date: _____

Patient's Last Name: _____ Patient's First Name: _____ Sex: M / F

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Allergies: _____

What is your primary reason for seeking treatment? Medical Cosmetic

What about your legs would you now most like to correct? _____
BE SPECIFIC

CHIEF COMPLAINT(S)

Do you experience any of the following symptoms in your legs?

Aching pain	Yes	No	**If yes**, where? _____
Burning	Yes	No	**If yes**, where? _____
Leg cramps	Yes	No	**If yes**, where? _____
Fatigue	Yes	No	**If yes**, where? _____
Heaviness	Yes	No	**If yes**, where? _____
Itching	Yes	No	**If yes**, where? _____
Restless legs	Yes	No	**If yes**, where? _____
Swelling	Yes	No	**If yes**, where? _____
Throbbing	Yes	No	**If yes**, where? _____

Other leg symptoms? _____

Are your symptoms worse at the end of the day? Yes No

How long have you had problems with your veins? _____

How do your symptoms interfere with your daily lifestyle?
Please list the activities (i.e. can't sleep at night, difficulty standing or sitting at work, difficulty performing household chores, difficulty taking care of children/grandchildren, problems walking due to leg pain, etc.)

_____

_____

What type of work do you do?_____

How do your leg symptoms limit your performance? _____

_____

Do you spend prolonged periods of **standing?** Yes No **sitting?** Yes No

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PREVIOUS ECS USE

Do you wear or have you ever worn elastic compression stockings? Yes No

Strength:_____

Name of the doctor they were prescribed by: _____

PREVIOUS VEIN TREATMENT

Have you seen any other doctors for treatment of your veins? Yes No

Name of the doctor: _____

Treatment type-

Endovenous laser ablation ..... Yes No ..... Date(s): _____

Phlebectomy..... Yes No ..... Date(s): _____

Sclerotherapy..... Yes No ..... Date(s): _____

Surgical stripping ..... Yes No ..... Date(s): _____

Other..... Yes No ..... Date(s): _____

CURRENT MEDICATION

Please list **all** of the medications that you currently take **(please include doses and frequency)**:

_____

_____

_____

Pharmacy name: _____ Pharmacy phone # or address: _____

MEDICAL HISTORY

History of Deep Vein Thrombosis..... Yes No ..... Details: _____

Klippel-Trenaunay Syndrome..... Yes No ..... Details: _____

History of leg ulcer ..... Yes No ..... Details: _____

Patent Foramen Ovale ..... Yes No ..... Details: _____

History of thrombophlebitis..... Yes No ..... Details: _____

Varicose Veins in the Buttock Area ..... Yes No ..... Details: _____

Varicose Veins in the Pelvic Area..... Yes No ..... Details: _____

Anemia ..... Yes No ..... Details: _____

Anxiety ..... Yes No ..... Details: _____

Bleeding disorders..... Yes No ..... Details: _____

Cancer ..... Yes No ..... Details: _____

Cholesterol ..... Yes No ..... Details: _____

Depression ..... Yes No ..... Details: _____

Diabetes ..... Yes No ..... Details: _____

If diabetic, ... Insulin dep. Non insulin dep. Diet controlled

Gastrointestinal problems ..... Yes No ..... Details: _____

Heart disease ..... Yes No ..... Details: _____
Hepatitis or other liver disease ..... Yes No ..... Details: _____
HIV/AIDS ..... Yes No ..... Details: _____
Hypertension ..... Yes No ..... Details: _____
Kidney problems ..... Yes No ..... Details: _____
Respiratory problems ..... Yes No ..... Details: _____
If yes, ... Asthma COPD Other: _____
Stroke… ..... Yes No ..... Details: _____
Thyroid disease ..... Yes No ..... Details: _____
Tuberculosis ..... Yes No ..... Details: _____
Other: _____

Have you ever been hospitalized before? Yes No
If yes, please specify **when** and **for what reason**:

_____

_____

Have you ever had surgery of any kind? Yes No
If yes, please state **when** and **explain**:

_____

_____

Have you had any complications after any of your surgeries? Yes No
If yes, please specify **when** and **for what reason**:

_____

If female-

Is there any chance you could be pregnant? Yes No Date of your last menstrual cycle: _____
How many times have you been pregnant? _____ How many times have you delivered? _____
Number of miscarriages _____ Dates of miscarriages _____
Number of elective abortions _____ Dates of abortions _____
Are you pregnant now? Yes No Are you currently breastfeeding? Yes No
Are you taking oral contraceptives? Yes No Are you taking hormone replacements? Yes No

FAMILY HISTORY

Do you have family history of varicose veins? _____ If so, who? _____
Family history of clotting disorders..... Yes No ..... Details: _____
Family History of Deep Vein Thrombosis.... Yes No ..... Details: _____
Family History of stroke..... Yes No ..... Details: _____

Do you have family history of any of the other previously mentioned conditions? Yes No
If yes, **which conditions** and **who** are the family members?

_____

_____

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SOCIAL HISTORY

How often do you exercise?_____

Do you smoke? Yes No If yes, packs/day: _____ How long have you been smoking?: _____

Do you drink alcohol Yes No If yes, how many drinks per week, on average?: _____

Do you tan regularly? Yes No If yes, how often?:_____

When was the last time you went tanning? _____

_____

ADDITONAL NOTES

Signature of Patient/Guardian:_____ Date:_____

STAFF INITIALS _____

PHYSICIAN INITIALS _____

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RELEASE STATEMENT
Consent to Use of Images/Video for Marketing/Educational Purposes

I, _____, whose signature appears below, hereby consent to
(PRINT FULL NAME)

the use of my images in photographs, illustrations, videos, or other likelihoods, for the

marketing/educational purposes of **Chicago Uptown Medical Center d/b/a Chicago**

Vein Institute.

Furthermore, I consent to the use of the following demographic information:

□ Age: _____
(PLEASE SPECIFY)

□ Gender: _____
(PLEASE SPECIFY)

□ Profession: _____
(PLEASE SPECIFY)

□ Ethnicity/Race: _____
(PLEASE SPECIFY)

Signature: _____Date: _____

Address: _____

City, State, Zip Code: _____

Signature of Parent/ Guardian: _____ Date:_____