

MINNEAPOLIS HEART INSTITUTE
Abbott Northwestern's Vascular Center & Vascular Specialists of MN
(612) 863-6800 (800) 582-5175
www.mplsheart.com/vascular

Appt. Date:

Dr:

Venous Medical Consultation

Date: _____ Name: _____

Marital Status: _____ Occupation: _____

Primary Physician: _____ DOB: _____

Age _____ Who referred you to our clinic? _____

Do you have children? If yes, how many? _____

Reason you are seeking treatment for your veins: _____ Medical reasons
_____ Cosmetic reasons

How long have you had the veins you are concerned about? _____

Did your veins develop during a pregnancy? _____

Does prolonged sitting or standing aggravate your veins? _____

Are your veins getting worse? _____

Have you ever had treatment for your veins? If yes, where and what type of treatment?

Do you have any of the following symptoms with your veins?
(please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> aches | <input type="checkbox"/> heavy/full feeling | <input type="checkbox"/> itching |
| <input type="checkbox"/> burning | <input type="checkbox"/> easy bruising | <input type="checkbox"/> muscle fatigue |
| <input type="checkbox"/> ulceration | <input type="checkbox"/> redness/inflammation | <input type="checkbox"/> bleed/hemorrhage |
| <input type="checkbox"/> pelvic symptoms | <input type="checkbox"/> leg restlessness | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> swelling after prolonged standing or sitting | | |

Have you ever been treated for a blood clot in your legs? If yes, when and which leg?

Do you or have you ever worn compression hose? If yes, for how long and did it help your veins?

Do any of your family members have the following conditions?

varicose veins

blood clots in the leg veins

Please circle any of the following medical conditions you have:

High blood pressure

Cancer

Heart disease

Lung disease

Diabetes

Liver disease

Kidney disease

Please list any pertinent medical condition you have that is not listed above:

Please list any previous surgeries and dates:

Please list all medications (including over-the-counter) you are taking:

Please list any allergies you have:

Do you smoke? If yes, how much? _____

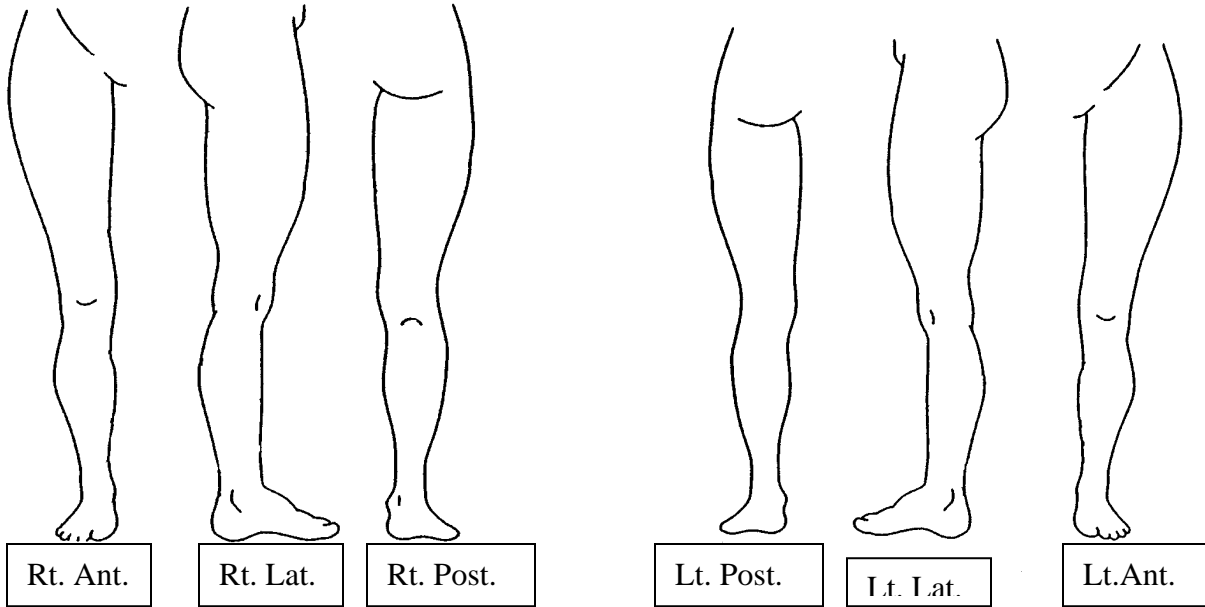
Did you previously smoke? _____ If yes, how much? _____

For how many years did you smoke? _____ When did you quit smoking? _____

Do you use alcohol? If yes, how much? _____

REMAINDER TO BE FILLED OUT BY STAFF

Upon examination patient has:



Pulses: (Right)
DP _____
PT _____

(Left)
DP _____
PT _____

Pictures taken: _____

Hose prescribed: _____

Review of Systems: (circle positives/cross out negatives)

- CONST – fever/ chills/ sweats/ fatigue/ appetite change/ temperature intolerance/ weight change
- CVS – chest pain/ heart murmur/ DVT/ PE/ edema/ palpitations
- SKIN – itching/ rashes/ sores/ lumps
- REPRODUCTIVE – sexual problems/ pregnancies
- MUSCULO-SKELETAL – joint pain/ swelling/ stiffness/ back pain/ neck pain

Physical Exam:

BP _____

Weight _____

General: _____

Heart: _____

Lungs: _____

Extremities: (see diagram)

Skin pigmentation? _____ LDS? _____

Ulcer? _____

Impression/Plan:

Nurse signature: _____

Date: _____

Physicians signature: _____

Date: _____

Patient Name: _____

Chart#: _____