pura vida
vein center & wellness spa

History and Physical

Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Social Security Number: _____ Marital Status: _____

Address: _____City/State/Zip: _____

Phone: _____ Insurance Provider: _____

How did you learn about us? _____

1. **What is your primary concern with the veins in your leg(s)?**

2. **Please circle any symptoms that you experience: R=Right L=Left**

Aching	R L	Swelling	R L
Fatigue	R L	Pain	R L
Burning	R L	Heaviness	R L
Throbbing	R L	Cramping	R L
Restless Legs	R L	Itching	R L

3. **How long have you been having symptoms? _____**
4. **Have they been getting worse? _____**
5. **Have you tried any of the following?**
   Over the counter support stockings/hoes Yes No
   Prescription support stocking/hoes Yes No
   If yes, when did you start wearing them? _____
   Do they provide relief? _____
   Pain Medication Yes No
   Elevating your legs Yes No
   Exercise Yes No
6. **Do you have a job where you are required to stand long hours on your feet? _____**
7. **Have you had your legs evaluated before?** Yes No
   Explain:
8. **Have you had previous surgery on your legs (i.e. vein stripping or sclerotherapy injections)**

   Yes No Explain: _____

9. **Who is your primary care physician? _____**
10. **Please list your medications**. _____

11. **Please list any allergies.** _____

Type of allergic reaction. _____

Please list any medical illnesses or diseases you have: _____

Have you ever had a Deep Vein Thrombosis (blood clots)? _____

Please list any surgeries you have had: _____

Please list any family history (i.e. varicose veins, deep vein thrombosis, pulmonaryemboli): _____

Please tell us your social history:

Do you smoke? Yes No **If yes, how long have you been a smoker?** _____ **How many a day?** ____

Please circle one: Married Single Divorced Widowed

Do you have children? Yes No **How many?** _____

What is your profession? _____

Do you have any of the following? Please circle.

Fever	High Blood Pressure	Constipation
Chills	Dizziness	Peptic Ulcers
Unintentional weight loss	Fainting	Hepatitis
Night Sweats	Asthma	Thyroid Dysfunction
Decreased Vision	Chronic Obstructive Lung	Diabetes
Sinus Trouble	Shortness of Breath	History of blood clots
Sore Throat	Cough	Bleeding Disorder
Chest Pain	Abdominal Pain	Palpitations
Coronary Artery Disease	Diarrhea	

Right GSV Reflux Yes____ No____

Right LSV Reflux Yes____ No ____

Left GSV Reflux Yes____ No ____

Left LSV Reflux Yes____ No ____