Vein Care Specialists of South Florida
Mark J. Marzano, M.D.

Patient Name: _____ Age: _____ DOB: _____ Today's Date: _____

Referring Doctor: _____ Referring Dr. Phone #: _____

Primary Care Doctor: _____ How did you hear about us: _____

Reason for visit: Please list when condition started, is it better or worse now and what tests/treatments have been done.

_____
_____
_____
_____
_____
_____

Any new medications started? _____

_____

If you have pain, please describe where it is located:

_____

Is it ____ continuous ___ occasional ___ episodic

Duration: (min./hrs., am/pm) _____

What type of pain do you feel? Aching, burning, tiredness, cramping, tenderness, throbbing, stabbing or numbness (circle all that apply)

What makes the pain feel better or worse?

_____

How would you rate the pain (1-10) _____

Past Medical History **List any other medical problems**

High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Seizures	Yes No
Diabetes	Yes	No	Thyroid Disease	Yes	No	Collapsed Lung	Yes No
Neuropathy	Yes	No	Emphysema/COPD	Yes	No	Asthma	Yes No
Heart Problems	Yes	No	Cancer	Yes	No	_____	
Heart Attack/MI	Yes	No	Bleeding? Ulcer	Yes	No	_____	
Heart Failure/CHF	Yes	No	Aneurysm	Yes	No	_____	
Stroke/CVA/TIA	Yes	No	DVT/Blood Clot	Yes	No	_____	
High Cholesterol	Yes	No	Varicose Veins	Yes	No		

Past Surgical History **Check all that apply and give date of occurrence then add all other**

__ Heart Bypass _____
__ Leg Bypass R/L _____
__ Vein Surgery R/L _____
__ Carotid Surgery R/L _____
__ Aortic Aneurysm _____
__ Hernia _____
__ Gallbladder _____
__ Thyroid _____
__ Other _____
_____

Has anyone in your family ever had	Father	Mother	Bro/Sis
Cancer _____	_____	_____	_____
Diabetes _____	_____	_____	_____
Hypertension _____	_____	_____	_____
Aneurysms _____	_____	_____	_____
Stroke _____	_____	_____	_____
Varicose Veins _____	_____	_____	_____

Social History

Alcohol __ Yes __ No if yes, how much _____
Tobacco Use __ Yes __ No Stop When _____
If yes, how much _____
Do you live alone? ____ Yes ____ No
What type of work do you do? _____
Does it require standing/sitting? _____
If yes, for how _____

Patient Name: _____ **DOB:** _____

Provide list of **all medications** and **dose** you are currently taking – include all natural supplements

_____

_____

_____

Allergies to medicine _____

Pain Medication _____

Review of Systems: Please circle or check all that apply.

Constitutional: fever, chills, weight loss/gain – lbs. _____ **or no problems** _____

Skin: ulcers, rash, itching, cellulitis, melanoma, basal cell cancer, squamous cell cancer, dermatitis or **or no problems** _____

Eyes: temporary loss of vision in one eye, blurred vision, cataracts, glasses **or no problems** _____

E.N.T. dentures, ear problems, hearing aid, nose bleeds, congestion, swallowing problems **or no problems** _____

Cardiac: chest pain, angina, chest pain with exertion, palpitations, leg swelling, ankle swelling **or no problems** _____

Respiratory: short of breath (SOB), wheezing, SOB when you lay down flat **or no problems** _____

GI: nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stools **or no problems** _____

GU: frequency, urgency, burning when you urinate, prostate problems, kidney disease **or no problems** _____

Musculoskeletal: pain in legs/calf when walking, sciatica, back pain, back disc disease, joint pain **or no problems** _____

Neurologic: dizzy, lightheaded, weak or numb on one side of arm/leg/face, headache, pass out **or no problems** _____

Psych: depression, anxiety, psychosis, rehab for drug or alcohol abuse **or no problems** _____

Endocrine: excessive thirst or urination, thyroid disease **or no problems** _____

Heme/Immune: HIV/AIDS, Hepatitis A, B, C, allergies, easy bruising, clotting disorder, abnormal periods **or no problems**_____

Varicose Veins/Spider Veins: If you are here for this condition, please circle all that apply

1. Do you experience any of the following?
   a. Aching in your legs..... Yes No
   b. Heaviness ..... Yes No
   c. Tiredness/Fatigue ..... Yes No
   d. Itching/Burning ..... Yes No
   e. Swollen ankles ..... Yes No
   f. Leg cramps..... Yes No
   g. Restless legs..... Yes No
   h. Throbbing..... Yes No
   i. Other..... Yes No
2. Have your veins gotten worse in recent months? ..... Yes No
3. Do you elevate your legs to relieve discomfort? ..... Yes No
4. Do you, or have you used any type of support/compression hose?..... Yes No
5. Do they provide relief? ..... Yes No
6. Are you taking any pain medicine?..... Yes No
   a. What type and how often?_____
7. Are you taking any iron supplements or vitamins with iron?..... Yes No
8. Have you ever has your veins evaluated before?..... Yes No
   a. If yes, when and where? _____
9. Have you ever has a superficial vein or varicose vein blood clot, phlebitis?..... Yes No
10. Have you ever had a deep vein thrombosos (DVT)?..... Yes No

Notes: _____

_____

Physicians Signature: _____ Date: _____

Patient Signature: _____ Date: _____