



## Activities of Daily Living

Please check all that apply, and make notes to elaborate.

### I feel discomfort when I:

Stand for \_\_\_\_\_ minutes or more in one place.

Walk for \_\_\_\_\_ minutes or more.

Sit for \_\_\_\_\_ minutes or more.

Drive or ride for \_\_\_\_\_ minutes or more.

### When I feel discomfort I:

\_\_\_\_\_ Change my position often.

\_\_\_\_\_ Try to ignore it and elevate my legs later.

\_\_\_\_\_ Take a break and elevate, then return to the activity.

\_\_\_\_\_ Take a pain pill (Tylenol, Aspirin, Ibuprofen, Etc) Please name:

**How often?** \_\_\_\_\_

**I would describe my pain as:** \_\_\_\_\_ Aching \_\_\_\_\_ Burning \_\_\_\_\_ Tightness \_\_\_\_\_ Cramping

\_\_\_\_\_ I sometimes awaken at night with leg pain/cramps.

\_\_\_\_\_ I sometimes find it hard to get to sleep due to discomfort.

\_\_\_\_\_ My legs feel "restless" at times.

\_\_\_\_\_ My legs feel better when I get up in the morning, but hurt later on.

\_\_\_\_\_ My legs sometimes swell.

\_\_\_\_\_ My legs sometimes itch.

### There are activities I can no longer do, or do less often, due to leg discomfort.

Please list:

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\_\_\_\_\_ My job involves a lot of sitting/standing and is harder due to discomfort.

\_\_\_\_\_ It hurts to play on floor with children/grandchildren.

\_\_\_\_\_ I find it more difficult to work-out/run/walk/ lift weights for exercise.

\_\_\_\_\_ I want/need to lose weight, but it's harder due to leg discomfort.



## History and Physical

**Patient Name:** \_\_\_\_\_ **Appointment date:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  M  F **Referred by:** \_\_\_\_\_  
**Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **PCP:** \_\_\_\_\_  
**Reason for Visit:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_

Please answer each question by checking Yes or No

### Past History:

	Yes	No
Stroke/TIA	___	___
Heart Disease	___	___
1. Heart attack	___	___
2. A Fib Angina	___	___
3. Heart Surgery	___	___
4. Angioplasty	___	___
Pacemaker/Defibrillator	___	___
High Blood Pressure	___	___
HIV/AIDS	___	___
Lung Disease	___	___
Kidney Disease	___	___
Diabetes	___	___
High Cholesterol	___	___
Hepatitis A B C (circle one)	___	___
Asthma COPD	___	___
Surgical History	___	___
Cancer	___	___
Anemia/Low Blood Count	___	___

### Medications:

**Please list current medications:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Allergies: None (circle if none)

	Yes	No
Latex	___	___
Medical allergies:	___	___
Please list: _____		
_____		

### Social History:

	Yes	No
Married	___	___
Current Tobacco Use	___	___
Years of use	___	___
Packs per day	___	___

### Family History:

	Yes	No
Stroke	___	___
Diabetes	___	___
Heart Disease	___	___
Cancer	___	___
Varicose Veins	___	___
Vascular Disease	___	___
Aneurysm	___	___

Have you ever worn support stockings \_\_\_\_\_  
 What kind? \_\_\_\_\_ Compression \_\_\_\_\_  
 How often? \_\_\_\_\_  
 Do you have leg pain/discomfort \_\_\_\_\_  
 Does the discomfort interfere with normal daily activities? \_\_\_\_\_  
 Do the stockings relieve leg discomfort? \_\_\_\_\_  
 Do the stockings cause leg discomfort? \_\_\_\_\_  
 Have you used analgesics for pain? \_\_\_\_\_  
 If yes, for how long \_\_\_\_\_

Have you been treated for any of the following:

	Yes	No	Left	Right
a. Phlebitis	___	___	___	___
b. Leg Ulcerations	___	___	___	___
c. Blood Clots	___	___	___	___
d. Pulmonary Embolism	___	___	___	___
e. Leg Fracture	___	___	___	___



**Current Complaint:**

Are you here for: Cosmetic Purposes \_\_\_\_\_ Medical Purposes \_\_\_\_\_

1. Indicate which of the following problems you have experienced:

- | a. Discomfort in your: | Yes   | No    | How Many Years |
|------------------------|-------|-------|----------------|
| 1) Thigh               | _____ | _____ | _____          |
| 2) Groin               | _____ | _____ | _____          |
| 3) Calf                | _____ | _____ | _____          |
| 4) Leg                 | _____ | _____ | _____          |
| 5) Foot                | _____ | _____ | _____          |

b. Swelling of the legs

2. When did your varicose veins occur? Age \_\_\_\_\_

- a. Before pregnancy
- b. During pregnancy
- c. After trauma
- d. After birth control/estrogen therapy
- e. Are you developing new veins
- f. Are your veins getting bigger

3. If you have experience discomfort in your legs

- | a. Indicate the type of discomfort | Yes   | No    |
|------------------------------------|-------|-------|
| 1) Resting discomfort              | _____ | _____ |
| 2) Resting cramps                  | _____ | _____ |
| 3) Night cramps                    | _____ | _____ |
| 4) Tiredness                       | _____ | _____ |
| 5) Heaviness in the legs           | _____ | _____ |
| 6) Numbness                        | _____ | _____ |
| 7) Burning                         | _____ | _____ |
| 8) Pain in a specific area         | _____ | _____ |

Area \_\_\_\_\_

- | b. Is the discomfort made worse by | Yes   | No    |
|------------------------------------|-------|-------|
| 1) Extended periods of standing    | _____ | _____ |
| 2) Heat                            | _____ | _____ |
| 3) Physical activity or walking    | _____ | _____ |
| 4) Medications                     | _____ | _____ |
| 5) Menstruation                    | _____ | _____ |
| 6) Intercourse                     | _____ | _____ |

- | c. Is the discomfort relieved by | Yes   | No    |
|----------------------------------|-------|-------|
| 1) Elevation                     | _____ | _____ |
| 2) Stockings                     | _____ | _____ |
| 3) Activity/walking              | _____ | _____ |

4. Have you ever been treated for this problem?  
Yes \_\_\_\_\_ No \_\_\_\_\_

By whom? \_\_\_\_\_  
When? \_\_\_\_\_

5. Treatment method used?

- \_\_\_\_\_ Injection
- \_\_\_\_\_ Electrocautery
- \_\_\_\_\_ Stockings
- \_\_\_\_\_ Surgery
- \_\_\_\_\_ Laser

6. If you have not been referred by your primary care physician, would you like copies of your reports forwarded to him/her? Yes \_\_\_\_\_ No \_\_\_\_\_

**Review of Systems:**

*Check all that apply*

**Constitution:**

- \_\_\_\_\_ Fever
- \_\_\_\_\_ Chills
- \_\_\_\_\_ Weight Loss
- \_\_\_\_\_ Night Sweats

**Neuro/Psych:**

- \_\_\_\_\_ Headache
- \_\_\_\_\_ Passed Out
- \_\_\_\_\_ Dizziness/Lightheadedness
- \_\_\_\_\_ Numbness/Tingling
- \_\_\_\_\_ Weakness
- \_\_\_\_\_ Difficulty Swallowing
- \_\_\_\_\_ Difficulty Speaking
- \_\_\_\_\_ Temporary Blindness

**HEENT:**

- \_\_\_\_\_ Runny nose
- \_\_\_\_\_ Sore throat
- \_\_\_\_\_ Difficulty hearing
- \_\_\_\_\_ Head injury

**MSK:**

- \_\_\_\_\_ Fractures
- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Neckpain
- \_\_\_\_\_ Muscle pain
- \_\_\_\_\_ Gout

**Respiratory:**

- \_\_\_\_\_ Difficulty Breathing
- \_\_\_\_\_ Coughing blood
- \_\_\_\_\_ Chronic cough
- \_\_\_\_\_ Wheezing

**Cardiovascular:**

- \_\_\_\_\_ Chest pain/discomfort (Circle one)
- \_\_\_\_\_ Pressure tightness squeezing
- \_\_\_\_\_ Irregular heartbeat/palpitations
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Leg/feet swelling

**Endocrine:**

- \_\_\_\_\_ Excessive thirst
- \_\_\_\_\_ Hair loss
- \_\_\_\_\_ Excessive sweating

**Vascular:**

- \_\_\_\_\_ Pain in legs while walking
- \_\_\_\_\_ Pain in legs while resting
- \_\_\_\_\_ Blood clots
- \_\_\_\_\_ Varicose veins

**GI:**

- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Constipation
- \_\_\_\_\_ Blood in stools
- \_\_\_\_\_ Nausea / vomiting
- \_\_\_\_\_ Heartburn /reflux
- \_\_\_\_\_ Pain after meals
- \_\_\_\_\_ Gallstones

**GU:**

- \_\_\_\_\_ Blood in urine
- \_\_\_\_\_ Painful urination
- \_\_\_\_\_ Excessive urination

**Skin:**

- \_\_\_\_\_ Rash
- \_\_\_\_\_ Ulcers

Physician Signature

*Ellen Derrick*  
MD MPH FACS