BOXBAR VASCULAR

www.BoxBarVascular.com

3216 NE 45th Place, Suite 207 | Seattle, WA 98105
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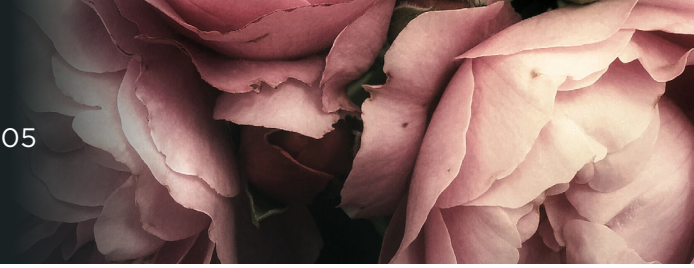

Activities of Daily Living

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:

_____

_____

_____

_____

_____

_____ 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.

Ellen Derrick
MD MPH FACS

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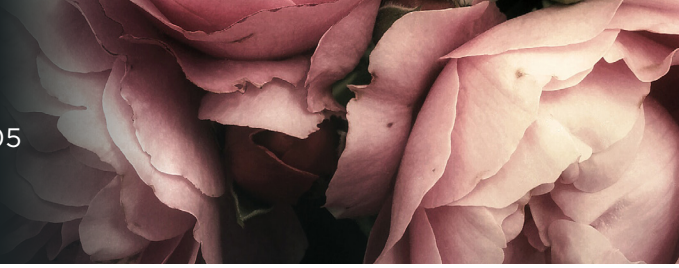

History and Physical

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	____	____	____	____

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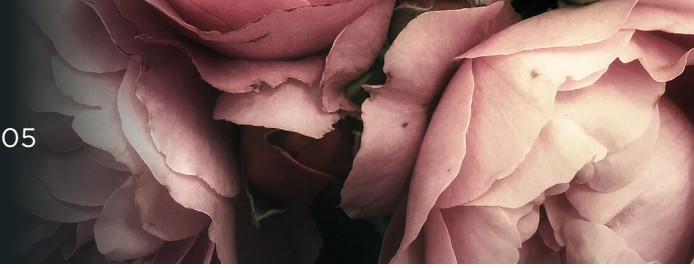

Current Complaint:

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 <u>not</u> 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

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