Peter Gregory, MD
Omar Dorzi, MD

Laura Slee, ARNP, DNP
Elizabeth Price, ARNP

New Patient Heath History

Name: ______________________________ **Date:** ____________________

Primary Care Physician: ____________________ **How did you find us?:** ____________________

Allergies: ☐ **None**	**Reactions:**

Medications: ☐ **None**	**Dose:**

Vein Symptoms/History of Present Illness (Please check all that apply)

☐ Painful veins
☐ Legs feels heavy
☐ Leg cramps or aches
☐ Leg burning, itching
☐ Leg swelling
☐ Restless legs
☐ Veins are enlarging

☐ Skin color changes
☐ Phlebitis
☐ Blood clots or DVT
☐ Ulcerations at ankles
☐ Spider Veins
☐ Facial Veins
☐ Symptoms worse w/ standing

☐ Compression stockings > 3 months
☐ Use leg elevation for symptoms
☐ Use pain meds for symptoms
☐ Regular exercise routine
☐ Weight loss program
☐ Prolonged sitting or standing daily
☐ Prior Injury to legs

Describe how your vein problems affect your daily living: ____________________

How long have your symptoms been present? ____________________

Past Medical History (Please check all that apply)

☐ High blood pressure ☐ High cholesterol ☐ Diabetes ☐ Kidney failure ☐ Asthma ☐ Thyroid
☐ Heart disease ☐ Cancer ☐ Lung disease ☐ Stroke ☐ Migraines

Details / Other: ____________________

Prior Vein Treatments (Please check all that apply)

☐ Vein Stripping
☐ Sclerotherapy
☐ Blood Thinners for DVT/PE

☐ Laser/Radiofrequency Vein Treatment
☐ Surface Laser Treatment
☐ Venous Stenting

Details / Other: ____________________

Past Surgical History (Please check all that apply)

☐ Gallbladder removal ☐ Heart bypass ☐ Hernia repair ☐ Carotid artery surgery
☐ Bowel surgery ☐ Leg/arm bypass ☐ Hysterectomy ☐ Appendectomy

Details / Other: ____________________

OB/GYN History

Are you pregnant or nursing? Yes or No
Do you have children? Yes or No How many pregnancies? __________

Family History (Please list any health conditions in your family, especially your mother, father, sisters, brothers)

____

____

Varicose Veins in family? Who? ____________________

____

Social History (Please check all that apply)

☐ Smoke **Packs per day?** __________ **Years?** __________ **Quit? When?** __________
☐ Drink Alcohol **Marital Status** __________ **Occupation:** ____________________

SOUND VASCULAR & VEIN

northwest vein center

Peter Gregory, MD
Omar Dorzi, MD
Laura Slee, ARNP, DNP
Elizabeth Price, ARNP

Review of Systems

Name: ______________________________ Date: ______________

General:
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight loss or gain

Eyes:
- ☐ Glasses or contact lenses
- ☐ Blurred or double vision
- ☐ Visual loss
- ☐ Pain
- ☐ Redness

Cardiovascular:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Leg Swelling

Respiratory:
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Emphysema
- ☐ Asthma
- ☐ Tuberculosis or TB

☐ **None of the above**

Gastrointestinal:
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel movements
- ☐ Bloody/black stool
- ☐ Vomiting blood
- ☐ Jaundice
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Stomach or duodenal ulcers

Musculoskeletal:
- ☐ Joint pain or stiffness
- ☐ Joint swelling
- ☐ Joint replacement
- ☐ Back pain
- ☐ Leg pain with walking
- ☐ Muscle weakness

Skin and Breast:
- ☐ Easy bruising
- ☐ Rash
- ☐ Sores/ulcers
- ☐ Hair loss
- ☐ Itching
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Abnormal mammogram

Neurological:
- ☐ Frequent headaches
- ☐ Numbness/tingling
- ☐ Head injury
- ☐ Stroke
- ☐ Memory loss
- ☐ Dizziness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Drug Abuse
- ☐ Alcohol Abuse

Endocrine:
- ☐ Diabetes
- ☐ Thyroid problems/goiter
- ☐ Heat or cold intolerance

Hematologic/Lymphatic:
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Anemia
- ☐ Enlarged glands
- ☐ Pacemaker
- ☐ AID or HIV positive

Allergic/Immunologic:
- ☐ Allergy to penicillin/other antibiotic
- ☐ Allergy to iodine or IVP dye
- ☐ Allergy to local anesthetic
- ☐ Food allergies
- ☐ Reaction to general anesthesia
- ☐ Seasonal Allergies
- ☐ Skin Rash

Gynecological:
- ☐ Irregular or heavy periods
- ☐ Bleeding between periods
- ☐ Menopause