

VEIN CENTER OF CENTRAL PENNSYLVANIA
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Date _____

Name _____ Age _____ Height _____ Weight _____

When did you first notice enlarged or discolored veins? _____
 Do they interfere with daily activities? _____ How? _____

Do you take any prescription medications for your legs? _____
 Do you take any over the counter medications? _____
 Have you worn support/compression hose? _____ How long have you worn them? _____
 Which leg bothers you most? Right _____ Left _____ Both _____

INDICATE THE SYMPTOMS YOU ARE OR HAVE BEEN HAVING, AND FOR HOW LONG

	Yes	No	How long		Yes	No	How long
Sharp pain	_____	_____	_____	Burning	_____	_____	_____
Dull pain	_____	_____	_____	Heaviness	_____	_____	_____
Aching	_____	_____	_____	Cramping	_____	_____	_____
Swelling	_____	_____	_____	Throbbing	_____	_____	_____
Itching	_____	_____	_____	Restless legs	_____	_____	_____
Leg Ulcers	_____	_____	_____	Tightness	_____	_____	_____
Tiredness	_____	_____	_____	Poor appearance	_____	_____	_____
Bleeding	_____	_____	_____				

INDICATE PAST MEDICAL PROBLEMS YOU HAVE EXPERIENCED AND WHEN

	When		When
Phlebitis	_____	Hospitalizations	_____
Deep Vein Thrombosis	_____	Pregnancies: how many	_____
Leg or ankle ulcers	_____	Miscarriages	_____
Painful varicose veins	_____	Last Menses	_____
Aids or HIV positive	_____	Allergic reactions:	
Diabetes	_____	medications	_____
Asthma	_____	adhesive tape	_____
		local anesthetics	_____
		detergents	_____

	Yes	No	
Is there a family history of:			
miscarriages	_____	_____	
heart attacks	_____	_____	(younger than 50) yes/no
stroke	_____	_____	(younger than 50) yes/no
pulmonary embolism	_____	_____	(younger than 50) yes/no

PLEASE SEE OTHER SIDE

List all current medications below including hormones, birth control pills, herbal, natural, or non prescription drugs or supplements _____

Have you ever had the following problems?

	When		Yes	No
Bad Scars (keloids)	_____	Leg pain at night	_____	_____
High Blood Pressure	_____	Leg pain with walking	_____	_____
Heart Disease	_____	Leg pain with standing	_____	_____
Hepatitis/Jaundice	_____	Previous vein sonogram/venogram?	_____	_____
Cancer	_____	Previous vein treatments	_____	_____
Major Surgery	_____			
Leg Surgery	_____			
Migraine Headaches	_____			

Do you smoke _____ How many packs per day? _____

Please list all family members with vein problems

Whom may we thank for referring you today? _____

FOR PHYSICIAN USE ONLY

Movie seen yes no

BP _____ P _____ R _____

Telangiactasis RIGHT _____ LEFT _____ SEVERITY _____

Reticulars RIGHT _____ LEFT _____ SEVERITY _____

Varicose veins RIGHT _____ LEFT _____

Size RIGHT _____ LEFT _____

SFJ REFLUX RIGHT _____ LEFT _____

SPJ REFLUX RIGHT _____ LEFT _____

SONOGRAM RIGHT _____ LEFT _____

Schedule for the following treatment _____

Rx given _____ Physician _____

