

NEWTON WELLESLEY SURGEONS, INC. – VNUS INTAKE FORM

TODAYS DATE: _____

NAME: _____ DATE OF BIRTH: _____

Height: _____ ft _____ in

Weight: _____ lbs

Do you smoke? YES NO

If yes how much: _____

Do you drink alcohol? YES NO

If yes how much: _____

1. When did you first notice enlarged veins? _____

2. Is one leg worse than the other? Right _____ Left _____ Same _____

3. How do the veins bother you? _____

- Sharp Pain YES NO
- Aches / Discomfort YES NO
- Congestion / Pressure YES NO
- Swelling YES NO
- Itching YES NO
- Appearance YES NO

4. Have you ever had these problems?

- Clots in legs (Phlebitis) YES NO Dates: _____
- Deep Vein Thrombosis YES NO Dates: _____
- Clots in Lungs (Embolus) YES NO Dates: _____
- Leg / Ankle Ulcers YES NO Dates: _____
- Vein X-Ray (Venogram) YES NO Dates: _____
- Taken Blood Thinners YES NO Dates: _____

5. Describe any experience with support stockings: _____

6. List all operations, hospitalizations, or serious illnesses:

_____ Dates: _____

_____ Dates: _____

_____ Dates: _____

7. Have you had previous injection therapy of your veins? YES NO Dates: _____

Results: _____

8. Do you or have you ever had the following?

- Diabetes YES NO Dates: _____
- Thyroid Disease YES NO Dates: _____
- High Blood Pressure YES NO Dates: _____
- Heart Disease YES NO Dates: _____
- Jaundice or Hepatitis YES NO Dates: _____
- Cancer YES NO Dates: _____
- Weight Change of 10lbs in the las six months YES NO Dates: _____
- Easy Bruising or free bleeding YES NO Dates: _____
- Leg Pain YES NO Dates: _____
- Major injury or surgery in your legs YES NO Dates: _____

9. Number of pregnancies? _____ Number of deliveries? _____ Dates: _____

10. Are you pregnant? YES NO

11. List hormones you've taken (including birth control pills) and dates of usage:

_____ Dates: _____

_____ Dates: _____

12. List current medications and dosages: _____

13. List all allergies: _____

14. Family members with vein problems:

Who: _____ Type: _____