HennepinHealthcare
Whittier Imaging

Patient Information

Date ___________ Date of Birth__________________ Sex Male _______ Female ________

Daytime Phone_____________________________ Work Phone _________________________________

How did you hear about us?

- ☐ Friend or family member
- ☐ Referring Physician
- ☐ Current Patient
- ☐ Website
- ☐ Phonebook
- ☐ Other__________________________

Vein History

Prior Evaluation ☐ Yes ☐ No Results____

Prior Testing ☐ Yes ☐ No Results____

Does your work require prolonged:

	Yes	No
☐ Sitting	_________	_________
☐ Standing	_________	_________

Treatment History

Treatments you have tried in the past:

	R leg	L leg	# of years
☐ Over the Counter Compression Stockings	________	________	______
☐ Prescription Compression Stockings	________	________	______
☐ Elevation	________	________	______
☐ Ambulatory Phlebectomy	________	________	______
☐ Surgery/Stripping	________	________	______
☐ Injections	________	________	______
☐ Laser Treatment	________	________	______
☐ Other ______________________________	________	________	______

Symptoms

	R leg	L leg	# of years
☐ Aching	________	________	______
☐ Bleeding	________	________	______
☐ Burning	________	________	______
☐ Cramps	________	________	______
☐ Discoloration	________	________	______
☐ Heaviness/Tiredness	________	________	______
☐ Numbness	________	________	______
☐ Pain	________	________	______
☐ Restless Leg	________	________	______
☐ Thrombophlebitis	________	________	______
☐ Ulcers	________	________	______
☐ Other ______________________________	________	________	______

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Medications

Are you taking any of the following medications?

	Yes	No
☐ Aspirin, Motrin, Ibuprofen, Nuprin, Etc.	________	________
☐ Blood Thinners (Coumadin, Etc.)	________	________
☐ Hormones or Contraceptives	________	________
☐ Chemotherapy	________	________
☐ Thyroid Medication	________	________
☐ Insulin	________	________
☐ Appetite Suppressants	________	________
☐ Blood Pressure	________	________

Past Medical History

- ☐ Phlebitis
- ☐ Ulcers
- ☐ Asthma
- ☐ Peripheral Vascular Disease
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ Hypertension
- ☐ Thrombus/Clot
- ☐ Trauma
- ☐ Seizures

Family History

- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Thrombus/Clot

Social History

Smoker	☐ Yes	☐ No
Previous Pregnancy	☐ Yes	☐ No
Planning Future Pregnancies	☐ Yes	☐ No

Allergies

Are you allergic to any of the following?

- ☐ Medications
  Explain____
- ☐ Latex
  Explain____
- ☐ Lidocaine
  Explain____

Miscellaneous

Is there any additional information you feel that you feel would be pertinent?

____

Signature ________________________________ Date:________________________