



SPECIAL MEDICAL HISTORY DATA FOR LEG PAIN / VARICOSE VEIN EVALUATION.
PLEASE TAKE A FEW MINUTES TO COMPLETE PRIOR TO YOUR OFFICE VISIT.

How did you learn about Dr. Gueldner or Wisconsin Vein Center (circle) Newspaper Radio Friend Physician Signage Yellow Pages

SECTION 1

Current problem(s) with legs - reason for this evaluation	Where is the pain:	<u>Right Leg</u>	<u>Left Leg</u>	<u>How Many Years?</u>
_____ Varicose veins	Back	_____	_____	_____
_____ Spider (small, spindly) veins	Lower limbs	_____	_____	_____
_____ Leg pain	Thigh	_____	_____	_____
_____ Aching, heaviness, tingling	Calf	_____	_____	_____
_____ Edema, swelling	Foot	_____	_____	_____
_____ Leg ulcer				
_____ Restlessness				

Is the pain exacerbated (made worse) by:	NO	YES	Is the pain alleviated (lessened) by:	NO	YES
long periods of standing	_____	_____	Walking or moving about	_____	_____
heat	_____	_____	Elevation of legs	_____	_____
cold	_____	_____	Lowering legs/feet	_____	_____
medications	_____	_____	Wearing elastic stockings	_____	_____
walking/exercising	_____	_____	How long have you worn them? _____		
menstrual periods	_____	_____	Other (specify) _____		
other (specify) _____					

SECTION 2

Do you have swelling or edema of the legs/ankles/feet?	NO	YES
If yes, which side	<i>Right</i>	<i>Left</i>
It is present in	<i>Morning</i>	<i>Evening</i>
Have you ever had an open sore or ulcer on your leg, ankle, toe?	NO	YES
Have you ever had superficial phlebitis?	NO	YES
(Tender, red, thickened cord along path of a vein)		
Have you ever had deep vein thrombosis?	NO	YES
(Blood clots in deep veins of leg)		
Were you hospitalized?	NO	YES
Were you given anticoagulants (blood thinners)?	NO	YES
Did this happen after pregnancy, surgery, injury?	NO	YES
(Please circle one if yes)		
Did the blood clot pass into your lung?	NO	YES
(Pulmonary Embolism)		
When did your vein problem first begin? _____		
Has it worsened in the past 6 to 12 months?	NO	YES

What type of work do you do? _____

In a usual day, how much time is spent standing?

10% of the day	_____
25% of the day	_____
30% to 50% of the day	_____
more than 50%	_____

LADIES

Date of last menstrual period _____		
Is there a possibility you might be pregnant?	NO	YES
Have you had a tubal ligation (sterilization) or hysterectomy?	NO	YES
Are you taking birth control pills?	NO	YES
Has your husband had a vasectomy?	NO	YES

Is there any other information of medical importance that you feel the doctor should know about? NO YES
 If yes, please indicate _____

I hereby consent for Dr. Gueldner or his staff to take photographs of my leg veins to assist in my treatment, document my problems for my insurance company and for use in educational settings as Dr. Gueldner deems useful.

Signed _____ Date _____