Massachusetts General Vein Care
21 Montvale Ave
Stoneham, MA 02180
781-438-8117 (F) 781-438-8116

New Patient VENOUS Questionnaire

Welcome to Massachusetts General Vein Care. Please fill out the following questionnaire, answering each question to the best of your ability. The information will assist your physician in better assessing your health status. *PLEASE PRINT CLEARLY.*

DATE: _____

Part I: GENERAL INFORMATION

Handedness: □Right □ Left // □Male □Female

Name: _____ **DOB:**_____ **Ht:** _____ **Wt:** _____

Address: _____ **MGH MR #:** _____

_____ **Home Phone: ( )**_____

Email: _____ **Cell Phone: (_____)**_____

Person to contact in case of emergency:_____**Relationship:**_____

Home phone: (_____)_____ **Work phone: (_____)**_____

Married/Divorced/Widow/Single/Legally Separated

Your (patient's) occupation: _____ **□ *Check if retired***

Primary Care Physician/Internist name: **Dr.** _____

Address: _____ **Office Phone:** _____

Names of other physicians/specialists actively involved in your care:

Dr. _____ **Location:** _____

Dr. _____ **Location:** _____

Who referred you for today's visit?_____

PHARMACY INFORMATION:

Pharmacy Name: _____

Address: _____

Telephone: (_____)_____-_____

***Medication Allergies:** □ **No known drug allergies** □ **Yes, Please list below:**

_____ _____

_____ _____

MEDICATIONS: Please list all the medications you are currently taking on a regular basis (include vitamins and over-the-counter medicines):

Medication name	**Dose (e.g. 50 mg)**	**Frequency (e.g. 3x/day)**	**Reason for taking**
1.			
2.			
3.			
4.			
5.			

***Habits*:**

Do you smoke cigarettes?

□ **Yes. How many packs per day? _____** **For how many years? _____**

□ **In the past. When did you quit? _____** **After _____ packs per day for _____ years**

□ **Never smoked**

Do you smoke cigars or pipes? □**Yes** □ **in the past** □ **never**

How much alcohol do you drink currently?_____ drinks/glasses per day or, _____ drinks/glasses per week.

Do you exercise regularly? □ **No** □ **Yes, what form of exercise? _____**

How many minutes per day? _____ or per week? _____

Female patients

# of pregnancies _____	**Are you currently breastfeeding?**	**□ Yes □ No**
# of children _____	**Are you pregnant?**	**□ Yes □ No**
Ages of Children _____	**Are taking birth control or other hormones?**	**□ Yes □ No**
Date of last menstrual period	**Have you had a tubal-ligation?**	**□ Yes □ No**
	Have you taken hormone replacement therapy?	**□ Yes □ No**
	Have you had a hysterectomy?	**□ Yes □ No**

Medical Conditions: **Please list all other medical conditions and surgical history with dates of occurrence *not included in Section III*.**

REASON FOR VISIT

□ Varicose Veins/Legs **□ Swelling** **□ Vascular Birthmark**

□ Leg Pain **□ Spider Veins/face** **□ Spider Veins/legs** **□ Other**

When did you notice this problem? _____

Please describe your expectations of therapy _____

Past Treatment

Have you ever been treated for the above problem(s)? □ No □ Yes

If yes, by whom? _____ When? _____

What Method?

□ Sclerotherapy **□ PhotoDerm** **□ Ablation right leg ___ left leg ___**

□ Surgery **□ Laser** **□ Other**

Have you ever worn support hose? □ Yes □ No □ Currently wearing them

Length of time you have worn the stockings for: _____

Do you use medication to relieve leg pain? □ No □ Yes If yes, list medication: _____

How often do you take the medication? □ **Daily** □ **As needed**

Does your problem interfere with your ability to work? □ **No** □ **Yes**

	Right	Left		Right	Left
Do you currently have:			***The leg pain is better:***		
Pain in your thigh?	□	□	**Elevation of the leg**	□	□
Pain in your calf?	□	□	**Compression hose**	□	□
Pain in your foot?	□	□	**Medication**	□	□
Ulcer on your legs	□	□	**Exercise/Walking**	□	□
Leg fatigue	□	□	**Other : _____**		

The pain is made worse with:			***Your pain feels like:***		
Standing	□	□	**Achy/tired/heavy**	□	□
Heat	□	□	**A cramp**	□	□
Before menses	□	□	**Burning**	□	□
Other	□	□	**Numbness**	□	□

FAMILY MEDICAL HISTORY

Please indicate if any of your first-degree relatives (i.e. your parents, siblings, and children) have had any of the following cardiovascular conditions. ***Please note the age of onset, if known.***

□ **Stroke**

□ **Bleeding in the brain**

□ **Sudden death**

□ **Venous Problems?**

who?

_____

what type? _____

□ **Irregular heart rhythms**

□ **Open heart surgery**

□ **Aortic Aneurysm**

□ **Clotting Problems?**

who? _____

what type? _____

□ **Heart Disease (Coronary Artery)**

□ **Heart Attack**

□ **Congestive heart Failure, weak heart, cardiomyopathy**

□ **Other cardiovascular proble**