



Albuquerque Vein & Laser Institute New Patient Intake Form

Name: _____ Date of Birth: _____

Vein History

Please next to the symptoms that apply to you: Aching leg Burning Tiredness
 Dull Pain Heaviness Itching Leg Ulcers
 Restless Legs Sharp Pain Swelling Throbbing
 Other: _____

Do you have (now or in the past): Varicose veins Spider veins Skin ulcer

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort? _____

Is the problem getting worse? Yes No

Where are the veins you are seeking a medical opinion for located? Face Leg(s), (Circle) Right Leg / Left Leg

Is the leg discomfort aggravated by: Standing Walking Exercise Other _____

Is the leg discomfort relieved by: Walking Laying down Medication Other _____

Have you ever worn prescription grade compression stockings? No Yes, When and for how long? _____

Do you have a family history of vein problems? No Yes, What family member? _____

Is there a family history of blood clots in the legs or lungs? No Yes, What family member? _____

Have you ever had any of the following:

Previous vein surgery? No Yes, When _____
Bleeding from veins? No Yes, When _____
Clotting disorder? No Yes, When _____
Deep vein blood clot (DVT)? No Yes, When _____
Pulmonary embolus (blood clot to lungs)? No Yes, When _____
Phlebitis (clot in surface vein of leg)? No Yes, When _____
Sclerotherapy? No Yes, When _____
Trauma/injury to your legs? No Yes, When _____
HIV/Hepatitis? No Yes, When _____
IV drug use? No Yes, When _____

Physician Plan
