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

_____
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_____

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