MARTIN'S Rejuvenation CENTRE

Varicose / Spider Vein Assessment

O ☐ S ☐ QB ☐ N ☐

Last Name:_____ First: _____ Initial: _____ Date: _____
Address: _____ City: _____ Postal Code: _____
Telephone: Home ( ) _____ Work ( ) _____
Cellular: ( ) _____ OHIP Number: _____
Date of Birth: Day _____ Month _____ Year _____ Age: _____ Email: _____
Occupation: _____ Are you pregnant, breastfeeding or trying to conceive? _____
Family Physician: _____ City: _____
How may we remind you of your appointment? ☐ Email OR ☐ No Reminder Please

How did you hear about us? MD Referral ☐ Internet ☐ Radio ☐ Facebook ☐ Instagram ☐
Referred by friend ☐ Who? _____ Magazine ☐ Tradeshow ☐

You may not have Sclerotherapy if you are pregnant, breastfeeding or three months after delivery.

PAST MEDICAL HISTORY

Past Medical History (ie. Cancer, HIV, Hep. C, Diabetes, Surgery etc.) _____

_____

_____

Current Medications including vitamins (dose not required) _____

_____

_____

Are you currently taking immunosuppressant medication? ☐ YES ☐ NO

Allergies (Include med treatments and environmental) _____

Do you suffer from any of the following symptoms?
☐ Burning ☐ Aching ☐ Swelling ☐ Itching ☐ Heaviness ☐ Throbbing ☐ No symptoms
How many years have you noticed this problem? _____ Number of children: _____
Which leg is worse? ☐ Right ☐ Left Do you smoke? ☐ YES ☐ NO
What percentage of your day is spent standing? _____% Exercise Level: ☐ Low ☐ Moderate ☐ High

Provide detail below – leave space empty if answer is NO ***If yes, please detail:***
Have you ever had trauma to your legs or pelvis? ☐ YES _____
Have you ever received treatment for varicose veins? ☐ YES _____
Are you taking hormone pills or oral contraceptives (birth control) ☐ YES _____

Do you have:			Have you ever had:	
	Diabetes	☐ YES	Phlebitis	☐ YES
	Cancer	☐ YES	D.V.T. (leg clot)	☐ YES
	Angina	☐ YES	Pulmonary Embolism (lung clot)	☐ YES
	Peripheral Vascular Disease	☐ YES	Leg Ulcers	☐ YES
			Hepatitis	☐ YES

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF: ☐ Varicose Veins ☐ DVT (leg clot) ☐ Blood Disorders _____
Have you ever had dizziness or fainting after having blood drawn? ☐ YES ☐ NO
Do you own compression stockings? ☐ YES ☐ NO *If so, please bring them with you for your next visit.*
Do you wear compression stockings? ☐ YES ☐ NO
Do you have an extended health plan? ☐ YES ☐ NO *If so, your plan may cover stockings*

_____ _____ _____
Patient Signature ***Date*** ***Physician/Nurse Signature***