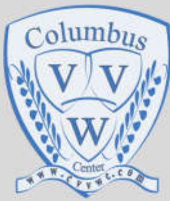

Columbus Vascular Vein & Wound Center

Initial visit form

First Name	Last Name	Age	Date of Visit
___________________________	___________________________	______	____________

Reason for your visit today?

Leg Pain ☐ Right ○ Left ○ Both ○	Leg Swelling ☐ Right ○ Left ○ Both ○	Leg Wound ☐ Right ○ Left ○ Both ○	Cold leg ☐ Right ○ Left ○ Both ○
Severity Duration________ 1 2 3 4 5 6 7 8 9 10	Duration? _____Months; _____Years	Duration? _____Months; _____Years	Picc Placement ○ Port Placement ○
Quality of pain Numb/tingles Sharp Dull Cramping Throbbing Aching Burning	Worse towards end of day? Yes ○ No ○ Worn compression stockings ? Yes ○ No ○	What dressing you put on wound_______________ ______________________ _________________	High Blood Pressure ○ Aneurysm ○ Raynauds ○
Pain related to walking? Yes ○ No ○	Visible veins in legs? Yes ○ No ○	Had wound in similar location in past? Yes/No	Concern for DVT ○ History of DVT/PE ○
Pain present at all times? Yes ○ No ○	Do leg veins hurt? Yes ○ No ○	Name of wound doc?	Non working Fistula ○
Pain worse in evening/night? Yes ○ No ○	Have you had vein procedures in past? Yes/No	Have you had vascular surgery in past? Yes/No	Do you have stents in legs? Yes/No

Currently Smoke cigarettes____ How many cigarettes per day smoked_____ No. of years smoked __________

Current/Past Medical problems, circle one	Imaging study Date/Place	Past Surgeries/ Year performed	Have you taken one of following medications? Circle applicable	
CHF, Heart failure, pacemaker	Leg Ultrasound _____	Heart Bypass _________	Coumadin/Warfarin	Presently taking?
Stroke/TIA, COPD, Asthma	CT leg ___________	Bypass in leg _________	Apixaban/Eliquis	Presently taking?
Heart attack, Diabetes	CT belly ___________	Vein stripping _________	Rivaroxaban/Xarelto	Presently taking?
Other:____________________	CT chest ___________	Aneurysm repair _________	Cilostazol/Pletal	Presently taking?
_________________________	ABI ___________	Radiation for cancer ______	Clopidogrel/Plavix/aspirin	Presently taking?
_________________________	Other:___________	Others:_________________	Cholesterol lowering	Presently taking?
_________________________	_________________	_______________________	Insulin/Lantus/novolog etc	Presently taking?
_________________________	_________________	_______________________	Metformin/Glipizide	Presently taking?

Name of Referring Physician:		
Name of Primary Care Physician:		
Height: & Weight		
List medicaton you are allergic to:		

Medication History

Medication Name (oral, injection, or topical)	Dosage	Frequency

Family History

Have any of your close relatives had:	Specify Relationship	deceased or alive?
Heart Disease		
Cancer		
COPD		
High Blood Pressure		
High Cholesterol		
Stroke		
Diabetes		
Seizure		
Thyriod Disease		
Arthritis		
Aneurysm		
Varicose Veins		
Peripheral Arterial Disease		

Social History

How much do you **drink**? beer/week	wine/week	liquor/week

Currently using **recreational drugs**? Name	Past usage? Name
Occupation	
Marital Status	
When did you get your last FLU shot?	
When did you get your last pneumonia vaccination?	

General
Fatigue
Night Sweats
General Weakness
Marked Weight Gain
Marked Weight Loss
Change in Appetite

HEENT
Dizziness
Tinnitus
Corrected Vision (glasses/contacts)
Loss of Vision
Eye Pain
"Floaters" in Field of Vision
Blindness
Loss of Hearing
Bleeding Gums
Painful Swallowing
Snoring
Nose Bleeds
Dentures
Neck Stiffness
Loss of Smell
Post Nasal Drainage

Respiratory
Shortness of Breath
Emphysema
Pulmonary Embolus
Productive Cough
Asthma
Lung Cancer
Sleep Apnea
CPAP/BiPAP Use
Oxygen Dependent
Tuberculosis
Wheezing
COPD
Tobacco Use
Drug Use
Lobectomy
Pneumothorax

Cardiovascular
Chest Pain
Congestive Heart Failure
Atrial Fibrillation
Palpitations
Pacemaker
ASV/VSD/PFO
Murmur
Blood Clots
Syncope
CAD

Cardiovascular Continued
Stents
CABG

Peripheral Vascular
Poor Circulation
PAD
Diabetes
Non-healing Wounds
Amputation
Claudication
Bulging Varicose Veins
Swelling
Skin Color Changes
Coolness in Extremities
Numbness/Tingling in Extremities
Pain in Extremities
Raynaud's Syndrome

Gastroenterology
Constipation
Vomiting
Coffee-Ground Emesis
Stomach Cancer
Decreased Appetite
Colon Cancer
Heartburn/GERD
Blood in Stool
Tar-like/Black Stool
Recent Change in Weight
Inflammatory Bowel Disease
Abdominal Pain

Musculoskeletal
Muscle Cramps
Joint Swelling/Stiffness
Weakness
Arthritis
Osteoarthritis
Rheumatoid Arthritis
Lupus
Degenerative Disc Disease

Neurological
Paralysis
Dementia
Dizziness/Vertigo
Syncope
Poor Balance
Numbness
CVA
TIA
Seizures
Restless Leg Syndrome
Migraines/Severe Headaches
Peripheral Neuropathy

Psychiatry
Depression
Anxiety
Bipolar Disorder
OCD
Dementia

Hematology
Anemia
Bleeding Disorder
Blood Clot (DVT)
Pulmonary Embolus
Superficial Blood Clot/
Thrombophlebitis
Bruising Easily
Hepatitis
HIV/AIDS
Cancer
Heparin-Induced Thrombocytopenia
(HIT)

Skin
Rash
Hair Loss
Change in Hair/Nails
Psoriasis
Dryness
Ulcers

Endocrine
Sensitive to Heat/Cold
Diabetes
Thyroid Problems
Goiter
Taking Thyroid Medication

Genitourinary
Hematuria
Difficulty Urinating
Frequent Urination
Bladder Infections
Kidney Disease
Dialysis

Any Additional Information

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