Kimmel Institute
LASER, VEIN & AESTHETIC CARE

Name: _____ Date: _____ DOB: _____

Patient Phone: _____ Family Physician: _____

E-mail: _____ Health Insurance: _____

How did you hear about us: _____ US Technologist _____

VASCULAR HISTORY: (please check all that apply)

Do you have or have you ever been diagnosed with:

- ☐ Blood clots R L
- ☐ Deep Vein Thrombosis (DVT) R L
- ☐ Phlebitis (Vein Redness/ Tenderness) R L
- ☐ Saphenous Vein Reflux R L
- ☐ Varicose Vein Problems R L

Do you ever experience any of the following in your legs?

- ☐ Achiness/pain R L
- ☐ Cramps R L
- ☐ Heaviness R L
- ☐ Itching/Burning R L
- ☐ Restless Legs R L
- ☐ Skin or ulcer problems R L
- ☐ Swelling R L
- ☐ Throbbing R L
- ☐ Tiredness/Fatigue R L
- ☐ Other: _____ R L

Which of the following do you currently do to improve your leg vein symptoms:

☐ YES ☐ NO Elevation of legs Duration: _____

☐ YES ☐ NO Medication for pain Duration: _____

☐ YES ☐ NO Wear support hose Duration: _____

VEIN TREATMENT HISTORY

Have you ever being treated for varicose veins with the following?

- ☐ Laser Ablation/RF R L
- ☐ Microphlebectomy R L
- ☐ Sclerotherapy R L
- ☐ Vein Stripping Surgery R L
- ☐ Chemical Ablation/ Foam R L

PERSONAL ACTIVITIES LIST:

(please check all that apply)

- ☐ YES ☐ NO Prolonged standing for work.
- ☐ YES ☐ NO Prolonged sitting for work.
- ☐ YES ☐ NO I exercise regularly.
- ☐ YES ☐ NO I smoke
- ☐ YES ☐ NO I have been pregnant before.

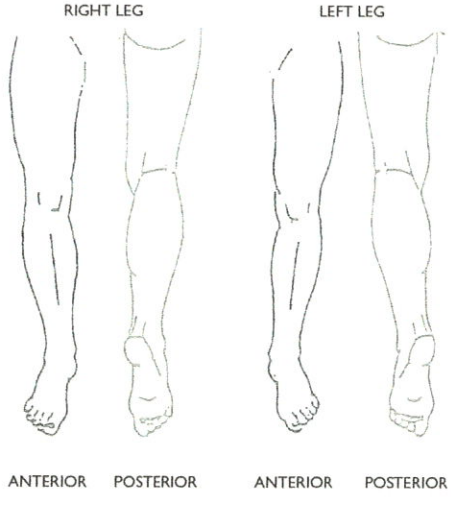
OFFICE USE ONLY. TO BE COMPLETED BY YOUR US TECHNOLOGIST.

RIGHT LEG (CHECK ALL THAT APPLY)

- ☐ No sign of venous disease ☐ Active ulcer ☐ Edema
- ☐ Visible signs of varicose veins ☐ Healed ulcer ☐ Pigmentation
- ☐ Spider Veins ☐ GSV Reflux ☐ SSV Reflux

LEFT LEG (CHECK ALL THAT APPLY)

- ☐ No sign of venous disease ☐ Active ulcer ☐ Edema
- ☐ Visible signs of varicose veins ☐ Healed ulcer ☐ Pigmentation
- ☐ Spider Veins ☐ GSV Reflux ☐ SSV Reflux



TREATMENT PLAN:

☐ Duplex Ultrasound ☐ Compression stockings

☐ Sclerotherapy ☐ Other: _____

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Medications, Vitamins, and Supplements

Patient Name: _____ Date: _____

Allergies: _____

Pharmacy name and # _____

Have you been vaccinated for Covid 19? Yes: _____ or No: _____
Please provide the date of vaccination and copy of vaccination card

Medication Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		