Mountcastle
Plastic Surgery & Vein Institute

Name _____ **Date** _____

Date of Birth / Age _____ **Email**_____

Preferred Pharmacy Name, Address and Phone number? _____
_____

For what problem are you seeking care for today? _____

First noticed when?_____ Location _____(R / L)

Severity / Size _____ Recent changes _____

Associated symptoms _____

Possible causes _____

Had a similar problem? (note when and how resolved) _____

Who referred you to the practice? _____

Who is your Primary Care Physician? _____

Medicines: (Dosage and how often)	Allergies to medicines:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
	To nickel—betadine—iodine?

Do you smoke? (How much)_____ Alcohol _____Drugs_____

Occupation:_____ Who is at home with you? _____

Past Surgeries:	

List number of pregnancies (if applicable):_____

Medical Problems you have (please **Circle** all that apply)

Arthritis	Diabetes	Kidney Problems	HIV/AIDS
Heart Problems	Asthma	Heart attack	Skin Disorders
Hepatitis	Stroke	TB	Anemia
Leg Ulcers	Gastric Reflux	Stomach Ulcer	High Blood Pressure
Depression	Anxiety	Bleeding Problem	High Cholesterol
Lung Problems	Hernia	Emphysema	Thyroid Disease
Clotting Problem/DVT		Cancer :(type) _____	

Review of Systems: Have you recently had any of the following? (**Circle** all applicable)

General:	Weight Loss or gain Vision changes	Cold or Flu Fainting	Fever Weakness on one side	Night sweats Seizures
Respiratory:	Trouble breathing	Awaking short of breath	Persistent cough	Short of breath while lying
Heart:	Chest pain	Arrhythmias	Heart attack	
GI:	Indigestion Blood in stool	Vomiting Constipation	Diarrhea	Abdominal pain
Urology:	Trouble passing urine	Peeing frequently	Peeing with great urgency	Pain urinating
Musculoskeletal:	Swelling of lymph glands	Back trouble	Arthritis	Muscle pain
Skin:	Skin trouble	Rash	Skin cancer	Open wound
Psychological:	Depression	Anxiety		
Vascular:	Varicose veins	Leg Cramping	Blood clots in legs	Leg pain
	Restless legs	Feet/Leg Swelling	Leg cramps	Ulcers
Endocrine:	Excessive thirst or urination	Feeling too hot / cold	Thyroid problems	

Family History: Circle any medical problems that run in your family.

Diabetes Bleeding/Clotting issues Cancer (what type)_____
Heart disease Stroke High blood pressure Varicose Veins Other:_____

Venous History (Legs): Circle any symptoms that apply.

Pain Aching Heaviness Burning Itching Bleeding
Redness Swelling Ulceration Skin discoloration Other:_____

What makes your symptoms better?_____
What makes your symptoms worse?_____
Have you ever been treated for varicose/spider veins?_____
If so, what type of treatment?_____