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Patient Name: _____

How did you hear about us?

- | | | |
|---|--|--|
| <input type="checkbox"/> Patient | <input type="checkbox"/> FL Weekly | <input type="checkbox"/> Internet Vein Directory |
| <input type="checkbox"/> Billboard | <input type="checkbox"/> WAVV 101 | <input type="checkbox"/> Naples National Network |
| <input type="checkbox"/> Car Magnets | <input type="checkbox"/> WAY FM | <input type="checkbox"/> Newspress |
| <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Telemundo | <input type="checkbox"/> Primary Physician |
| <input type="checkbox"/> Grandeur | <input type="checkbox"/> Vein Screening | <input type="checkbox"/> Church Bulletin |
| <input type="checkbox"/> Parent & Child | <input type="checkbox"/> Vein Van | <input type="checkbox"/> FI Health Care News |
| <input type="checkbox"/> SW Health & Wellness | <input type="checkbox"/> WeKnowVeins.com | <input type="checkbox"/> Gulf Shore Life |
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Home Show | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Your Health Monthly | <input type="checkbox"/> Ins. Company | <input type="checkbox"/> Other_____ |

Why are you here today?

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain in Legs | <input type="checkbox"/> Bleeding from Veins | <input type="checkbox"/> Leg Cramps at Night |
| <input type="checkbox"/> Swelling in Legs | <input type="checkbox"/> SVT | |
| <input type="checkbox"/> Bulging/Varicose Veins | <input type="checkbox"/> Spider Veins | |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Reticular/Blue Veins | |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Restless Legs | |
| <input type="checkbox"/> Stasis Dermatitis | <input type="checkbox"/> Other_____ | |

Which Leg? Right Left Both

How long have you had the above? _____ Days Weeks Months Years

Previous Treatments:

- | | |
|--|--|
| <input type="checkbox"/> Anti-Inflammatories | <input type="checkbox"/> Injection Sclerotherapy |
| <input type="checkbox"/> Compression Hose | <input type="checkbox"/> Laser Sclerotherapy |
| <input type="checkbox"/> Elevation | <input type="checkbox"/> Stripping |
| <input type="checkbox"/> Endovenous Closure | <input type="checkbox"/> Varicose Vein Excision |
| <input type="checkbox"/> None | <input type="checkbox"/> Other_____ |

Made worse by:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Menstrual Cycle |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Working | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Beginning of Day | <input type="checkbox"/> End of Day | <input type="checkbox"/> Pregnancy |
| | | <input type="checkbox"/> None |

Improved by:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Elevation | <input type="checkbox"/> Compression Hose | <input type="checkbox"/> Fluid Pills |
| <input type="checkbox"/> Rest | <input type="checkbox"/> Tylenol/Motrin Equivalent | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Beginning of Day | <input type="checkbox"/> End of Day | <input type="checkbox"/> Other_____ |
| | | <input type="checkbox"/> None |

Alcohol: Never Rare Socially Daily **Smoking:** Never Quit > 10 years Quit < 1 year Smoker

Number of Pregnancies: _____ Number of Deliveries: _____

Past Surgeries:

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Groin Dissection | <input type="checkbox"/> TAH/Hysterectomy |
| <input type="checkbox"/> Athroscopy | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> THR/Hip Replacement |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Injection Sclerotherapy | <input type="checkbox"/> TKR/Knee Replacement |
| <input type="checkbox"/> Balloon/Stent Heart | <input type="checkbox"/> Vena Caval Filter | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Balloon/Stent Leg | <input type="checkbox"/> Leg Bypass | <input type="checkbox"/> Vein Excision |
| <input type="checkbox"/> Colectomy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Vein Stripping |
| <input type="checkbox"/> Endovenous Closure | <input type="checkbox"/> Skin Graft | <input type="checkbox"/> Laser Sclerotherapy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Stomach Bypass | <input type="checkbox"/> Other _____ |

Allergies:

- | | | |
|----------------------------------|---|--|
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> LOCAL ANESTHETIC | <input type="checkbox"/> PCN /PENICILLIN |
| <input type="checkbox"/> LATEX | <input type="checkbox"/> MYCINS | <input type="checkbox"/> PRESERVATIVES |
| <input type="checkbox"/> IODINE | <input type="checkbox"/> SULFA | <input type="checkbox"/> NONE |

Family History:

Relation	What
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Past Medical History:

- | | | |
|--|-----------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Blockages | <input type="checkbox"/> Diabetes | <input type="checkbox"/> NONE |

Have you had ANY of the following?

SKIN

- Itching
- Hives
- Bruising
- Bleeding

EYES

- Vision changes or loss
- Double vision

EARS

- Hearing aids
- Hearing loss
- Pain
- Discharge
- Ringing

CARDIOVASCULAR

- Palpitations
- Shortness of Breath
- when sleeping
- when walking
- Legs swelling
- cramps
- Varicose veins
- Color changes
- legs/feet

GASTROINTESTINAL

- Vomiting
- Constipation
- Diarrhea

NEUROLOGICAL

- Headaches
- Dizziness
- Numbness
- Falls
- Tremors
- Stroke/TIA's
- Loss of memory
- Problems with gait
- Restless Legs

PSYCHIATRIC

- Depression
- Anxiety
- Bipolar

- Infections

NOSE

- Nosebleeds
- Discharge
- Infections
- Pain

MOUTH/THROAT

- Cavities
- Dentures
- Bleeding Gums
- Sores/Lesions
- Hoarseness

NECK

- Goiter
- Pain
- Thyroid problems

RESPIRATORY

- Cough
- Blood
- Shortness of breath
- Asthma
- Emphysema
- Tuberculosis
- Pneumonia
- Bronchitis

- Heartburn

- Blood in stool
- Changes in stool
- Difficulty/pain
- in swallowing
- Jaundice
- Liver Disease
- Gallbladder Disease

GENITOURINARY

- Urine frequency
- Pain
- Bloody urine
- Incontinence

LYMPHATIC

- Anemia
- Sickle Cell
- Hemophilia
- Swollen Glands
- Night sweats
- Itching

ENDOCRINE

- Increased thirst
- Increased urine
- Intolerance to heat
- Intolerance to cold
- Diabetes
- Hot flashes

ALLERGY/IMMUNE

- AIDS
- Hepatitis B
- Hepatitis C

MUSCULOSKELETAL

- Weakness
- Paralysis
- Stiffness
- Joint pain
- Swelling
- Arthritis
- Gout
- Calf Cramps