Yorkville Vein Clinic
Confidential Patient History for Leg Veins

Name _____Date of Birth (dd/mm/yy) ____/_____/_____Age:____

Address _____ City _____

Province _____ Postal Code _____ E-mail Address:_____

Home Telephone _____ Work Telephone _____

Health Card # _____ Version Code _____ (one or two letters on card)

Family Doctor _____ Referring Doctor (if any) _____

Would you like us to send a report to your family/referring doctor? Yes No

How did you learn about our clinic(circle one)? Website Fashion Magazine Elevate

Toronto Life Word of Mouth Other Physician

Yorkville Vein Clinic Also Offers:

Laser Hair Removal Facial Vein Treatment Hand Vein Treatment

Would you like more information on the above services: Y N If Yes, please circle (above)

Venous History

1. Which leg would you like treatment for? Right Left Both

2. Have you ever had your veins evaluated before Yes No
   If so, by whom and when? _____
   Did they perform any tests on your veins? (Example: Ultrasound)_____

3. Do you wear support hose prescribed by a doctor? Yes No
   If yes what compression and do they provide relief? _____ Yes No

5. Have you ever had any vein procedure? Surgery EVLT Yes No
   If yes, what leg? Right Left Both

6. Have you ever had vein sclerotherapy (injections)? Yes No
   If yes, what leg? Right Left Both
   When? _____

7. Have you ever had any deep venous thrombosis (DVT or blood clots)? Yes No
   If yes, what leg? Right Left Both

8. Have you ever had phlebitis of your varicose veins? Yes No
   If yes, what leg? Right Left Both

9. Do you experience any of the following symptoms?

_____

Aching/pain in your legs	Yes	No	R	L	Heaviness	Yes	No	R	L
Tiredness/fatigue	Yes	No	R	L	Itching/burning	Yes	No	R	L
Swollen Ankles	Yes	No	R	L	Leg Cramps	Yes	No	R	L
Restless Legs	Yes	No	R	L	Throbbing	Yes	No	R	L

Any other symptoms? _____

10. How long have you experienced these symptoms? Year(s)_____

11. Does walking help the discomfort? Yes No

12. Do you stand much at work or home? Yes No How long?_____

13. How do you relieve the discomfort in your legs? Elevate Walk

Medical & Surgical History

1. Do you have:

Anemia	Yes	No _____	Heart Disease	Yes	No _____
Thyroid	Yes	No _____	Lung Disease	Yes	No _____
Hepatitis	Yes	No _____	Pacemaker	Yes	No _____
Diabetes	Yes	No _____	Leg Ulcer	Yes	No _____
Asthma	Yes	No _____	High Blood Pressure	Yes	No _____
Arthritis	Yes	No _____	**Previous Surgery:**_____		

2. Are you presently under the care of a physician? Yes No

   If yes, please indicate who and for what illness or purpose._____

3. Please list all current medications (prescription & non- prescription)

Medication:	Dosage	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take blood-thinning medications? Yes No

4. Do you have any allergies? (example: medicine, food or pollen)

Describe how they affect you: (example: rash, hives, shortness of breath)

_____	_____
_____	_____
_____	_____

Social History

What is your profession? _____

Women only: Child Bearing History

1. Do you think you are presently pregnant? Yes No
2. How many children have you had? _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date_____

Questionnaire Ends Here, Thank You.

YORKVILLE VEIN CLINIC

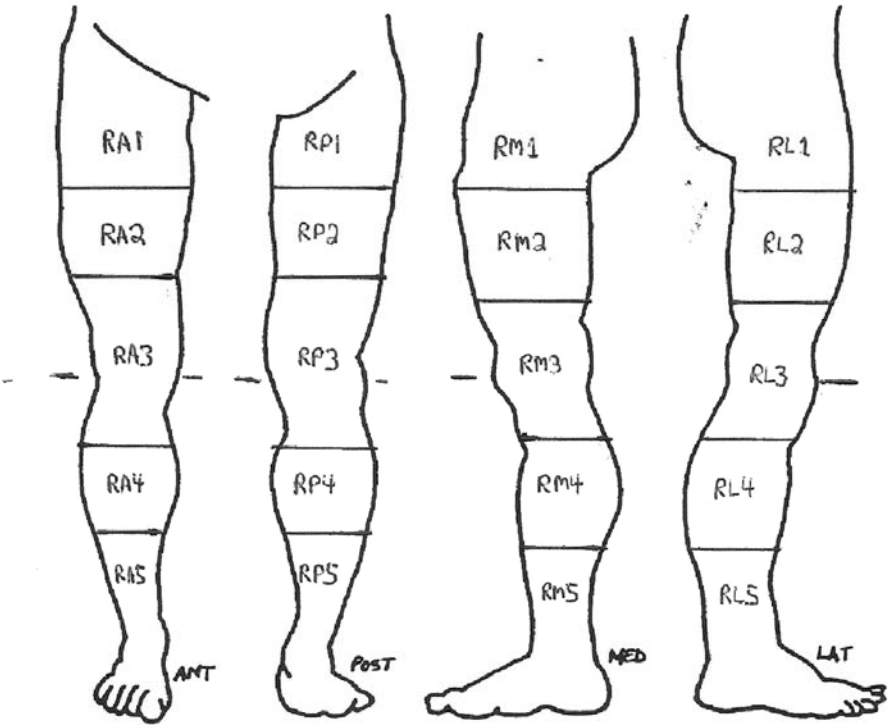
SCLEROTHERAPY RECORD

Name_____ Date_____

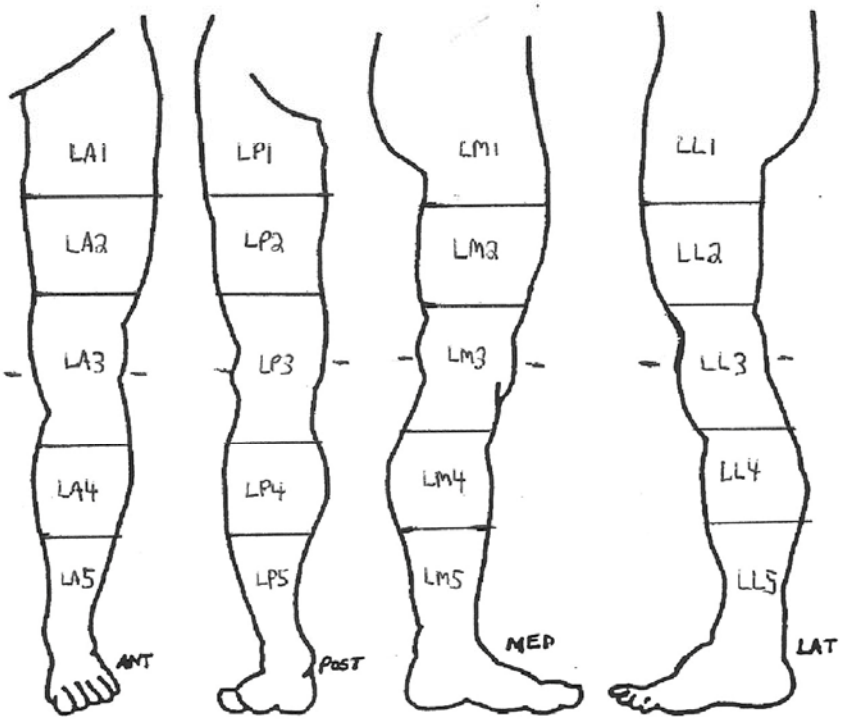
_____

_____

RIGHT LEG



LEFT LEG



YORKVILLE VEIN CLINIC
VENOUS INSUFFICIENCY ULTRASOUND ASSESSMENT

RIGHT LEG VENOUS DUPLEX ULTRASOUND:

Great Saphenous Vein:	**No Reflux**	**Reflux**	**Segmental**	**Absent**
Diameter:				
Small Saphenous Vein:	**No Reflux**	**Reflux**	**Segmental**	**Absent**
Diameter:				
Deep Venous Reflux:	**No Reflux**	**Reflux**	**Segmental**	
DVT:	**No**	**Yes**		
Popliteal vein	*Superficial Femoral Vein*		*Common Femoral Vein*	
Baker's Cyst:	**No**	**Yes**		
Size:				
Mass:	**No**	**Yes**		

LEFT LEG VENOUS DUPLEX ULTRASOUND:

Great Saphenous Vein:	**No Reflux**	**Reflux**	**Segmental**	**Absent**
Diameter:				
Small Saphenous Vein:	**No Reflux**	**Reflux**	**Segmental**	**Absent**
Diameter:				
Deep Venous Reflux:	**No Reflux**	**Reflux**	**Segmental**	
DVT:	**No**	**Yes**		
Popliteal vein	*Superficial Femoral Vein*		*Common Femoral Vein*	
Baker's Cyst:	**No**	**Yes**		
Size:				
Mass:	**No**	**Yes**		

LIMITED PELVIC ULTRASOUND:

Inferior Vena Cava Visualized:	**No**	**Yes**
Retroperitoneal Mass:	**No**	**Yes**
Pelvic Mass:	**No**	**Yes**

Treatment Recommendations:

EVLA: GSV: Right Left SSV: Right Left
Price:
Ambulatory Phlebectomy: Right: Left: Price:

Small Vein: Right Leg: 3 Left Leg: 3 Notes:
Price:

Laser/Sclero 1 1.5 2 3 Laser Only Sclerotherapy Only

Comments: Monica only Monica & Dr. Kundu Dr. Kundu only

YORKVILLE VEIN CLINIC

Duplex Assessment

Reflux Assessment:

In Standing (or steep reverse trendelenburg if necessary)

- Reflux sources: GSV SSV Perforators Tributaries Other
- Reflux time: Rt: SFJ:_____sec SPJ:_____sec Other:_____

Symbol	
~	Tortuosity
a	Aneurysmal
md	Min diameter of segment to be treated:_____mm
Md	Max. diameter of segment to Be treated:_____mm
A1	Optimal Access point(s) and Diameter(s): _____mm
A2	_____mm
Sv	Superficial Vein-depth<10mm
P	Significant Perforator
P-i	Incompetent Perforator
T	Significant Tributary
T-i	Incompetent Tributary
DS/AS	Dual or accessory saphenous

Note: If assessment is performed a few days before Scheduled EVLT, map vein with skin marker now.