

THE VEIN INSTITUTE OF TORONTO & MEDICAL AESTHETIC CENTRE™  
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

**The Vein Institute of Toronto™ 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	_____	<b>Previous Surgery:</b>	_____		

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.**

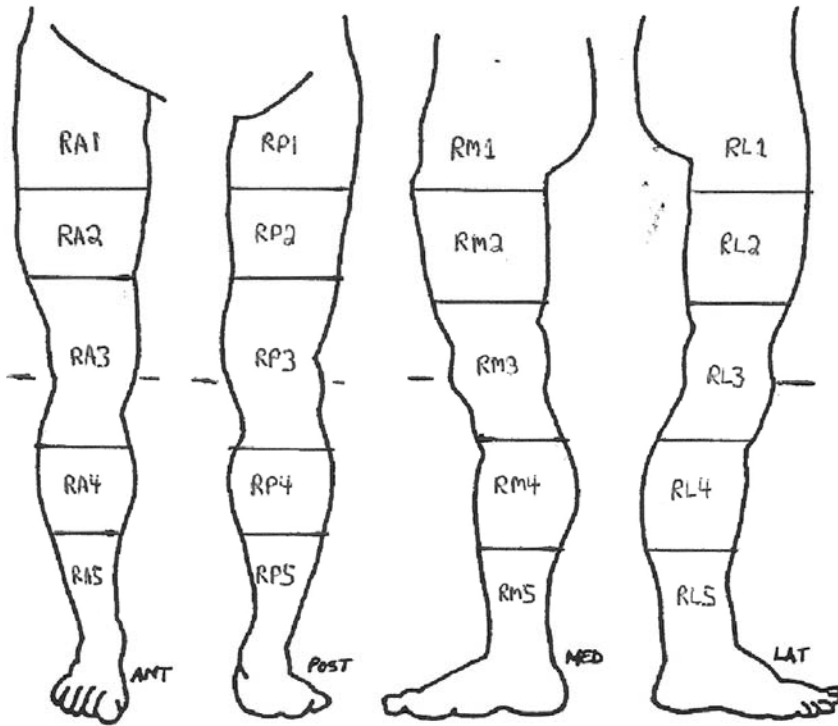
# THE VEIN INSTITUTE OF TORONTO™

## SCLEROTHERAPY RECORD

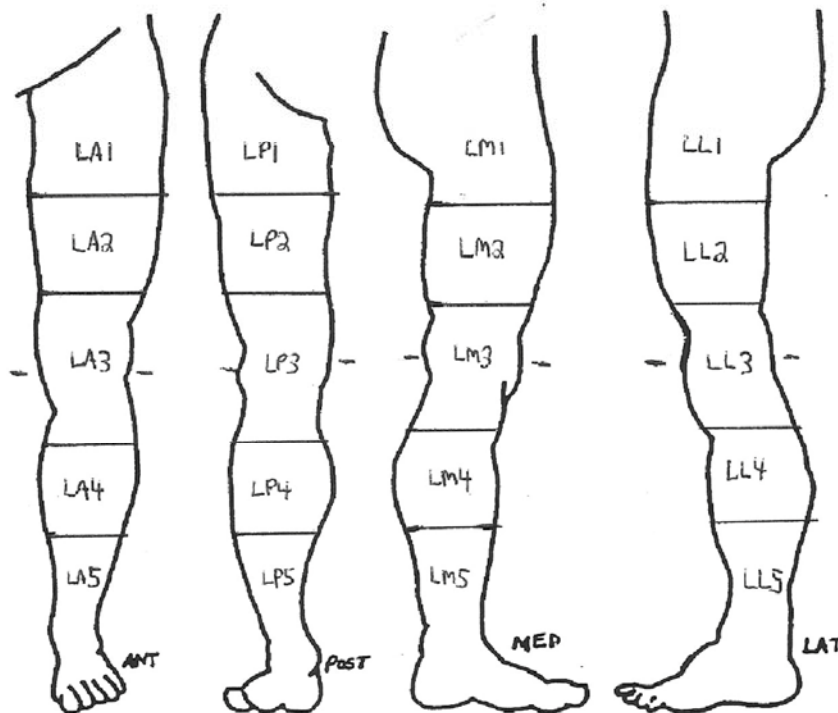
Name \_\_\_\_\_

Date \_\_\_\_\_

### RIGHT LEG



### LEFT LEG



**THE VEIN INSTITUTE OF TORONTO™**  
**VENOUS INSUFFICIENCY ULTRASOUND ASSESSMENT**

**RIGHT LEG VENOUS DUPLEX ULTRASOUND:**

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

**LEFT LEG VENOUS DUPLEX ULTRASOUND:**

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

**LIMITED PELVIC ULTRASOUND:**

Inferior Vena Cava Visualized:	<b>No</b>	<b>Yes</b>
Retroperitoneal Mass:	<b>No</b>	<b>Yes</b>
Pelvic Mass:	<b>No</b>	<b>Yes</b>

**Treatment Recommendations:**

<b>EVLA: GSV:</b>	<b>Right</b>	<b>Left</b>	<b>SSV: Right</b>	<b>Left</b>
<b>Price:</b>				
<b>Ambulatory Phlebectomy:</b>	<b>Right:</b>	<b>Left:</b>	<b>Price:</b>	
<b>Small Vein: Right Leg:</b>	<b>3</b>	<b>Left Leg:</b>	<b>3</b>	<b>Notes:</b>
<b>Price:</b>				
<b>Laser/Sclero</b>	<b>1</b>	<b>1.5</b>	<b>2</b>	<b>3</b>
		<b>Laser Only</b>		<b>Sclerotherapy Only</b>
<b>Comments:</b>	<b>Monica only</b>	<b>Monica &amp; Dr. Kundu</b>		<b>Dr. Kundu only</b>

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## 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.

