ORTHOMIAMI

Patient Name: _____ **Date:** _____

Insurance: _____ **DOB:** _____

Do you experience any of the following in your leg(s)? *(Please answer Yes or No / Which Leg: Right leg, left leg or both legs?)*

Aching/Pain ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Heaviness ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Bulging Varicose Veins ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Tiredness fatigue Fatigue ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Spider Veins & Leg Pain ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Itching/Burning ❑ Y ❑ N
Leg(s): ❑ R ❑ L

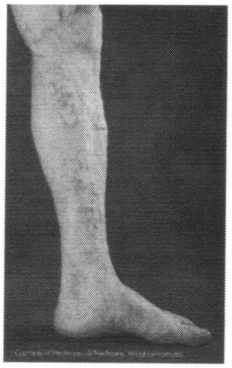
Swelling/Edema ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Cramps/Throbbing ❑ Y ❑ N
Leg(s): ❑ R ❑ L

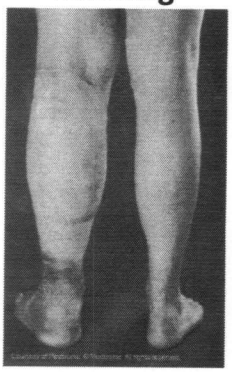
Restless Legs ❑ Y ❑ N
Leg(s): ❑ R ❑ L

Non-Healing Wounds/Ulcers ❑ Y ❑ N
Leg(s): ❑ R ❑ L

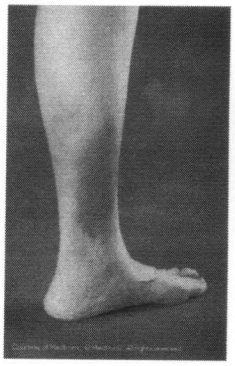
Bulging Varicose Veins



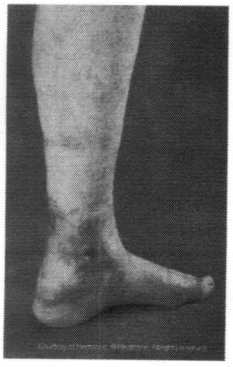
Swelling



Skin Changes



Ulcer



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