Venous Health History Form

Patient Name: ____________________________  Date of Birth: ______________

Directions: Please answer all the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping or ablation?  □ Yes  □ No
   If yes, when and which leg? _______________________________________

2. Have you ever had vein injections?  □ Yes  □ No
   If yes, which leg and where on the leg? _____________________________
   What Solution was used? __________________

3. Have you ever had a blood clot?  □ Yes  □ No
   If yes, which leg and when? _______________________________________

4. Have you ever had phlebitis?  □ Yes  □ No
   If yes, which leg and when? _______________________________________

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father  □ Yes  □ No
Mother  □ Yes  □ No
Brother(s)  □ Yes  □ No
Sister(s)  □ Yes  □ No
Other  □ Yes  □ No

1. Do you experience any of the following in your legs?
   Aching/pain?  □ Right leg  □ Left leg
   Heaviness?  □ Right leg  □ Left leg
   Tiredness/fatigue?  □ Right leg  □ Left leg
   Itching/burning?  □ Right leg  □ Left leg
   Swollen ankles?  □ Right leg  □ Left leg
   Leg Swelling?  □ Right leg  □ Left leg
   Leg cramps?  □ Right leg  □ Left leg
   Restless legs?  □ Right leg  □ Left leg
   Throbbing?  □ Right leg  □ Left leg
   Varicose veins?  □ Right leg  □ Left leg
   Spider Veins?  □ Right leg  □ Left leg
   Leg ulcer?  □ Right leg  □ Left leg

Do you have pelvic or vaginal varicose veins? □ YES □ NO
Are you veins more painful during your menstrual cycle? □ YES □ NO
Do you experience pain during intercourse? □ YES □ NO
Please rate your pain:  No Pain □  Moderate Pain □  Severe Pain □
Other? ________________________________

Which leg is most painful?  □ Right leg □ Left leg  Rate the pain. 1 (no pain)-10 (severe pain) ____

2. Have your veins gotten worse in recent months? □ Yes □ No

3. Do you take any medication for pain (i.e., Advil, Motrin) □ Yes □ No
If yes, what medication do you take and how many times/mgs per day? ________________

4. Do you elevate your legs to relieve discomfort? □ Yes □ No
If yes, how long per day do you elevate and does it provide relief? __________________

5. Do you exercise? □ Yes □ No
If yes, what kind of exercise and how often? __________________
Have you had recent weight loss? ______  How much? ______
Height: ______  Weight: ______

6. Do you wear prescription compression stockings? □ Yes □ No
If yes, what type and gradient? 15-20  □  20-30 □  30-40 □
How long have you worn them? __________________
If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? __________________

8. Do you have any problem walking? □ Yes □ No
If yes, how does it affect you? __________________

9. What type of work do you do? __________________
How long do you stand (hours per day) at work? ________________ At home? ________________

10. Have you ever had any test(s) done on your veins? □ Yes □ No
If yes, when and what type of test and where on the leg? __________________

11. Were you diagnosed with saphenous vein reflux? □ Yes □ No

12. Current Physicians that you see: __________________

13. How did you hear about us? __________________

Patient Signature: __________________________ Date: __________