

### Venous Health History Form

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. What are your symptoms/problems? (circle all that apply)

- |                            |     |    |   |                                   |                                 |
|----------------------------|-----|----|---|-----------------------------------|---------------------------------|
| Leg pain/discomfort        | yes | no | <input type="checkbox"/> mild                       | <input type="checkbox"/> moderate | <input type="checkbox"/> severe |
| Phlebitis                  | yes | no | <input type="checkbox"/> recurrent (more than once) |                                   |                                 |
| Bleeding varicose veins    | yes | no |   |                                   |                                 |
| Ulcers or open sores       | yes | no |   |                                   |                                 |
| Swelling in legs or ankles | yes | no |   |                                   |                                 |

2. What conservative measures have you taken to alleviate symptoms? (circle all that apply)

- |                             |              |                                    |                                |                                |                              |
|-----------------------------|--------------|------------------------------------|--------------------------------|--------------------------------|------------------------------|
| Leg elevation               | yes          | no                                 |                                |                                |                              |
| Exercise                    | yes          | no                                 |                                |                                |                              |
| Over the counter analgesics | yes          | no                                 |                                |                                |                              |
| Weight loss                 | yes          | no                                 |                                |                                |                              |
| Compression stockings:      | yes          | no                                 |                                |                                |                              |
| How long? _____             | Compression? | <input type="checkbox"/> Not Known | <input type="checkbox"/> 20-30 | <input type="checkbox"/> 30-40 | <input type="checkbox"/> 40+ |

3. Describe how your symptoms interfere with your job function or the activities of your daily routine.

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#### Family History

4. Has anyone in your family had varicose veins, spider veins, leg ulcers, or swollen legs?    yes    no

5. Name of referring physician and how long have you been under his/her care for treatment of this condition?

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To the best of my knowledge, the above information is accurate and complete.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)