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Venous Health History Form

Patient Name:_____ Date of birth: _____

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

Past Medical History

1. 1.Have you ever had vein stripping surgery? c Yes c No
   If yes, when and which leg? _____

2. Have you ever has vein injections? c Yes c No
   If yes, which leg and where on the leg?_____

3. Have you ever had a blood Clot? c Yes c No
   If yes, when and which leg? _____

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

Family History

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

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

1. Do you experience any of the following in your legs?

Aching/pain	c Yes	c No	cOne leg	c Both legs
Heaviness	c Yes	c No	cOne leg	c Both legs
Tiredness/fatigue	c Yes	c No	cOne leg	c Both legs
Itching/burning	c Yes	c No	cOne leg	c Both legs
Swollen ankles	c Yes	c No	cOne leg	c Both legs
Leg cramps	c Yes	c No	cOne leg	c Both legs
Restless legs	c Yes	c No	cOne leg	c Both legs
Throbbing	c Yes	c No	cOne leg	c Both legs

Other _____

2. Have your veins gotten worse in recent months? c Yes c No
   Describe: _____

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

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

5. Do you exercise? c Yes c No
   If yes, what kind of exercise and how often? _____
   _____

6. Do you wear prescription compression stockings? c Yes c No
   If yes, what type and gradient? How long have you worn them?_____
   _____

7. Do you wear light support hose (i.e. Sheer Energy) c Yes c No
   If yes, do they provide relief? c Yes c No

8. Do you have any problem walking? c Yes c No
   If yes, describe how it interferes with your activities of daily living, which activities? ____
   _____
   _____

9.What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: _____
   _____

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

11. Were you diagnosed with Saphenous vein reflux? c Yes c No

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

1. Patient Signature: _____ Date: _____