

Vein Care Solutions

Venous Health History Form

Patient Name: _____ Date of Birth: _____
Age _____ Sex _____ Height _____ Weight _____
Referred by _____

Medical History

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

- | | | | | |
|---------------------|------------------------------|-----------------------------|----------------------------------|------------------------------------|
| Aching? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Burning? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Cramping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Heaviness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Itching? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Throbbing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Tiredness/fatigue? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Swollen ankles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |
| Rash/discoloration? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> One leg | <input type="checkbox"/> Both legs |

2. How many years have you had this problem?

3. Have you ever been treated for this problem? Yes No

By whom? _____ When? _____

By which method?

Injection _____ Laser (surface) _____ Catheter _____ Surgery _____

4. Have you ever been treated for one of the following?

Phlebitis (inflammation of a vein) Yes No R/L leg

Pulmonary embolism/blood clot Yes No R/L leg

Leg ulcer? Yes No R/L leg

5. When did your veins appear?

Age _____ Before/During/After pregnancy _____ After

trauma _____

After birth control pills _____ After hormonal therapy _____

6. Have you ever been pregnant? Yes No

If so, how many children have you delivered? _____

7. Are you developing new veins? Yes No

8. Are your existing veins getting bigger? Yes No

9. Does walking or exercise relieve aggravate the pain? (check one)

10. Do you take any medication for pain (i.e., Advil, Motrin) Yes No

11. Rate the intensity of pain (check one)

No pain	Mild	Moderate	Severe	Excruciating						
0	1	2	3	4	5	6	7	8	9	10

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

13. Do you wear prescription compression stockings? Yes No
If yes, what strength/gradient? How long have you worn them?

14. In the course of a normal day, how much time is spent in the following positions?
Check one

Standing:	Sitting:
10% of the day _____	10% of the day _____
20% of the day _____	20% of the day _____
30 to 50% of the day _____	30 to 50% of the day _____
More than 50% _____	More than 50% _____

15. Are your symptoms interfering with your daily activities? Yes No
How?

Do you have a family history of

- a. Varicose vein problems? Yes No
Family member(s) _____
- b. Phlebitis/Blood Clots Yes No
Hospitalizations _____

Do you have any allergies to medications? Please list

Do you have a history of

- | | | | |
|--------------------|--|---------------------|--|
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autoimmune disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Migraine headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | |

Please list current medications

Please list any previous surgeries and year

Signature: _____ Date: _____