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Venous Health History Form

Patient Name:_____ **Date of Birth:**_____

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

Past Medical History

Have you ever had vein stripping surgery? ____Yes ____ No If yes, when & which leg?_____

Have you ever had vein injection? ____Yes ____ No If yes, which leg & where on the leg?_____

Have you ever had a blood clot? ____Yes ____ No If yes, which leg & when?_____

Have you ever had phlebitis? ____Yes ____ No If yes, which leg & when?_____

Family History

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

Father ____Yes ____ No

Mother ____Yes ____ No

Brother ____Yes ____ No

Sister ____Yes ____ No

Other ____Yes ____ No

Do you experience any of the following in your legs?

Aching/Pain ____Yes ____ No ____ One Leg ____ Both Legs

Heaviness ____Yes ____ No ____ One Leg ____ Both Legs

Tiredness/Fatigue ____Yes ____ No ____ One Leg ____ Both Legs

Itching/Burning ____Yes ____ No ____ One Leg ____ Both Legs

Swollen Ankles ____Yes ____ No ____ One Leg ____ Both Legs

Leg Cramps ____Yes ____ No ____ One Leg ____ Both Legs

Restless Legs ____Yes ____ No ____ One Leg ____ Both Legs

Throbbing ____Yes ____ No ____ One Leg ____ Both Legs

History of Ulcers ____Yes ____ No ____ One Leg ____ Both Legs

Other ____Yes ____ No ____ One Leg ____ Both Legs

If you have not answered yes to any of the above questions, please stop here.

Patient Signature:_____ Date:_____

Venous Health History Form

Patient Name:_____ **Date of Birth:**_____

Have your veins gotten worse in recent months? ____Yes ____ No

Do you take medication for pain (i.e. Advil, Motrin)? ____Yes ____ No

If yes, what medication do you take & how many times/mgs per day?_____

Do you elevate your legs to relieve discomfort? ____Yes ____ No

If yes, how long per day do you elevate & does it provide relief?_____

Do you exercise? ____Yes ____ No If yes, what kind of exercise & how often?_____

Do you wear prescription compression stockings? ____Yes ____ No

If yes, what type & gradient? How long have you worn them?_____

If yes, what is the physicians' name who prescribed the compression stockings & when were they prescribed?

_____

Do you wear light support hose (i.e. Sheer Energy)? ____Yes ____ No

If yes, do they provide relief? ____Yes ____ No

Do you have any problems walking? ____Yes ____ No

If yes, how does it affect you?_____

What type of work do you do?_____

How long do you stand (hours per day) at work?_____ At home?_____

Have you ever had any test done on your veins? ____Yes ____ No

If yes, when and what type of test and where on the leg?_____

Were you diagnosed with saphenous vein reflux? ____Yes ____ No

Patient Signature:_____ Date:_____