Vein History Form

GENERAL INFORMATION	
Today's Date:	Clinic Location:
Patient Name:	Date of Birth: _____/_____/_____

SYMPTOMS					
Aching/Pain in legs:	☐ Y ☐ N	Throbbing:	☐ Y ☐ N	Hepatitis:	☐ Y ☐ N
Heaviness:	☐ Y ☐ N	Swelling:	☐ Y ☐ N	High Blood Pressure:	☐ Y ☐ N
Tiredness/Fatigue:	☐ Y ☐ N	Asthma/COPD:	☐ Y ☐ N	Diabetes:	☐ Y ☐ N
Itching/Burning/Warmth:	☐ Y ☐ N	Heart Disease:	☐ Y ☐ N	Cancer:	☐ Y ☐ N
Leg Cramps:	☐ Y ☐ N	Peripheral Arterial Disease:	☐ Y ☐ N	Leg Trauma/Surgery:	☐ Y ☐ N
Restlessness Leg:	☐ Y ☐ N	HIV:	☐ Y ☐ N		
Do your symptoms interfere with your sleep?: ☐ Y ☐ N					
Are your symptoms worse later in the day?: ☐ Y ☐ N					
Are your symptoms worse with or after activity?: ☐ Y ☐ N					
Do your symptoms keep you from doing anything?: ☐ Y ☐ N					
Does prolonged sitting or standing aggravate your legs?: ☐ Y ☐ N					
How long have you had problems with your veins?: _____ ☐ Months or ☐ Years					
Do your legs effect your daily living?: ☐ Y ☐ N		If yes how?:			

Do you have any Peripheral Arterial Disease (PAD) Symptoms?
Was diagnosed with PAD in past: ☐ Y ☐ N
Have/had cramping leg pain that worsens with walking, forcing me to stop walking: ☐ Y ☐ N
Feet/Toes become pale and painful with exercise or when elevating them: ☐ Y ☐ N
Have/had ulcers on feet or toes: ☐ Y ☐ N

Conservative Measures used currently or previously					
Pain Medication:	☐ Y ☐ N	Weight Loss:	☐ Y ☐ N	Leg Elevation:	☐ Y ☐ N
Job Change:	☐ Y ☐ N	Exercise:	☐ Y ☐ N		
Prescribed Compression stockings/hose or leg wraps?: ☐ Y ☐ N					
Please list your weight: _____ lbs and height: _____ ft _____ in					

Have you ever had any vein treatments? (check any that apply)		
☐ Pain Medications	☐ Exercise	☐ Weight Loss
☐ Compression Stockings	☐ Sclerotherapy	☐ Endovenous Ablation
☐ Venaseal	☐ Stab Phlebectomy	☐ Physical therapy
☐ Varithena Therapy	☐ Laser Therapy	☐ Leg Elevation

OFFICE USE ONLY
Blood Pressure: _____ / _____ R L Patient ID#: _____
Staff Signature: _____ Date: _____
Provider Signature: _____ Date: _____