Venous Health History Form

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

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

Past Medical History

1. Have you ever had vein stripping or ablation? ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
   What Solutions was used? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

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

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

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

Aching/pain?	☐ Right leg	☐ Left leg
Heaviness?	☐ Right leg	☐ Left leg
Tiredness/fatigue?	☐ Right leg	☐ Left leg
Itching/burning?	☐ Right leg	☐ Left leg
Swollen ankles?	☐ Right leg	☐ Left leg
Leg Swelling?	☐ Right leg	☐ Left leg
Leg cramps?	☐ Right leg	☐ Left leg
Restless legs?	☐ Right leg	☐ Left leg
Throbbing?	☐ Right leg	☐ Left leg
Varicose veins?	☐ Right leg	☐ Left leg
Spider Veins?	☐ Right leg	☐ Left leg
Leg ulcer?	☐ Right leg	☐ Left leg

Please rate your pain: **No Pain** ☐ **Moderate Pain** ☐ **Severe Pain** ☐

When did Pain begin? _____

Pain is brought on by what activities? _____

Which leg is most painful? ☐ Right leg ☐ Left leg **Rate the pain**. 1 (no pain)-10 (severe pain) ____

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No

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

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

5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____
   Have you had recent weight loss? _____ How much? _____
   Height: _____ **Weight: _____**

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
   If yes, what type and gradient? 15-20☐ 20-30☐ 30-40☐
   How long have you worn them? _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

8. Do you have any problem walking? ☐ Yes ☐ No
   If yes, how does it affect you? _____

9. What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____

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

11. Were you diagnosed with vein reflux? ☐ Yes ☐ No

12. Current Physicians that you see: _____
    _____

13. How did you hear about us? _____

Patient Signature: _____Date: _____

Thank you for choosing Southern Vein Care