



## VENOUS HEALTH HISTORY FORM

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PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Doctor's Name: \_\_\_\_\_

Directions: Please answer the following questions. Provide your best estimate for dates of occurrence.

### Past Medical History

1. Have you ever had vein stripping surgery?  Yes  No

If yes, when and which leg? \_\_\_\_\_

2. Have you ever had vein injections?  Yes  No

If yes, when, which leg and where on the leg? \_\_\_\_\_

3. Have you ever had a blood clot?  Yes  No

If yes, when and which leg? \_\_\_\_\_

4. Have you ever had phlebitis?  Yes  No

If yes, which leg and when? \_\_\_\_\_

5. Do you experience and of the following?

A: Aching/pain in your legs?  Yes  No

B: Heaviness?  Yes  No

C: Tiredness/Fatigue?  Yes  No

D: Itching/Burning?  Yes  No

E: Swollen Ankles?  Yes  No

F: Leg Cramps?  Yes  No

G: Restless Legs?  Yes  No

H: Throbbing?  Yes  No

Other: \_\_\_\_\_

Do you experience these problems in just one or both legs?  ONE  BOTH

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

7. Do you take any medication for pain (e.g. advil, etc.)?  Yes  No

If yes, what medication and how often? \_\_\_\_\_

8. Do you elevate your legs to relieve discomfort?  Yes  No

9. Do you wear support hose prescribed by a doctor?  Yes  No

If yes, what type and how long have you worn them? \_\_\_\_\_

10. Do you wear grade compression stockings?  Yes  No

11. Do they provide relief?  Yes  No

12. Do you have any problems walking?  Yes  No

If yes, how does it affect you? \_\_\_\_\_

13. Do you stand much at work?  Yes  No

At home?  Yes  No

14. Have you ever had any test(s) done on your veins?  Yes  No

If yes, when, what type, and where on the leg(s)? \_\_\_\_\_

15. Were you diagnosed with saphenous vein reflux?  Yes  No

Any other comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Family History

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

If yes, who and what did they have? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_