Vein Health History

Patient Name: ______________________ Date: ____________________________

Have you ever had vein stripping or other vein surgery?	Yes	No
If yes, when and which leg: ____		
Have you ever had vein injections?	Yes	No
If yes, which leg and where on the leg: ___________________________________		
Have you ever had a blood clot or phlebitis?	Yes	No
If yes, which leg and when: ____		
Have you ever had any tests such as an ultrasound performed on your veins?	Yes	No
If yes, which leg and when: ____		
Have you/do you wear prescription support/compression hose?	Yes	No
If yes, what strength and how long have you worn them: ____________________		
Do you take any over-the-counter pain medication for your symptoms?	Yes	No
If yes, what medication and how long have taken it: ________________________		

Do you experience any of the following symptoms? (Please circle)

Aching/pain in your legs	Yes	No..............Left..............Right..............Both Legs
Heaviness	Yes	No..............Left..............Right..............Both Legs
Fatigue/tiredness	Yes	No..............Left..............Right..............Both Legs
Itching/burning	Yes	No..............Left..............Right..............Both Legs
Swollen ankles	Yes	No..............Left..............Right..............Both Legs
Leg Cramps	Yes	No..............Left..............Right..............Both Legs
Restless legs	Yes	No..............Left..............Right..............Both Legs
Throbbing	Yes	No..............Left..............Right..............Both Legs

How long have you had these symptoms? ______________ years/months

Have your symptoms worsened in recent months?	Yes	No
Do you have a problem walking?	Yes	No
Do you have a problem standing for long periods?	Yes	No
Do your symptoms interfere with other daily activities?	Yes	No
If yes, please elaborate: ____		
Do you stand much at work?	Yes	No
Do you stand much at home?	Yes	No

Are your symptoms worse with (Please circle all that apply):
Sitting........... Walking........... Menstrual Cycle........... Standing........... Lying Down
Beginning of Day........... End of Day........... Pregnancy........... None of these

Are your symptoms improved by (Please circle all that apply):
Elevation........... Compression........... Fluid Pills........... Rest........... Tylenol/Motrin Equivalent
Walking........... Beginning of Day........... End of Day........... None of these