

PATIENT VENOUS HISTORY

Patient Venous History

Patient Name: _____ Date of Birth: _____

Please Circle

- | | | |
|--|------------|----------|
| 1. Have you had any previous treatment(s) for varicose/spider veins?
If yes, date(s) of treatment(s): _____
Type of agent(s) used, if known: _____ | Yes | No |
| 2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis? | Yes | No |
| 3. Do you have a family history of varicose/spider veins?
If so, relationship(s) to you? _____ | Yes | No |
| 4. Are you currently, or have you been on any hormone therapy or birth control pills?
If so, please list: _____ | Yes | No |
| 5. Have you had any pregnancies? If so, how many? _____
If so, did your varicose/spider veins increase after your pregnancies? | Yes
Yes | No
No |
| 6. Do you wear support hose?
If yes, are they prescription or over the counter? _____ | Yes | No |
| 7. Are you presently employed? If so, type of job: _____
How long: _____ | Yes | No |
| 8. Do you sit or stand for long periods of time?
How many hours per day? _____ | Yes | No |
| 9. Do you take any medication for the pain in your legs?
If so, does it work? | Yes
Yes | No
No |
| 10. Do you elevate your legs to relieve your symptoms?
If so, does it work? | Yes
Yes | No
No |
| 11. Do you have any medication allergies?
If so, please list: _____ | Yes | No |

Comprehensive History Checklist (Please check all that apply)

	Right Leg	Left Leg
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Skin Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Spider Veins	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Date: _____