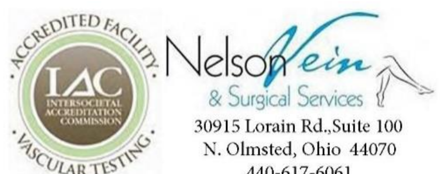


# VENOUS HEALTH HISTORY FORM

| Name: | DOB: | Sex: ☐ M ☐ F | Date: |
|---|---|---|---|
| PCP Name: | How did you hear about us? ☐ Physician Referral: _______________ | | |
| Referring Physician: | ☐ Internet ☐ TV ☐ Radio ☐ Newspaper ☐ Other __________ | | |

| I. Vascular History | | |
|---|---|---|
| **Do you have or have you ever been diagnosed with:** | | |
| Varicose vein problems | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Phlebitis (vein redness/tenderness) | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Blood clots | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Deep vein thrombosis (DVT) | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Saphenous vein reflux | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| **Do you experience any of the following in your leg(s)?** | | |
| Aching/Pain | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Heaviness | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Tiredness/Fatigue | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Itching/Burning | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Swelling | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Cramping | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Restless legs | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Throbbing | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Skin or Ulcer problems | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Other: | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| **Do you do any of the following to improve your leg vein symptoms:** | | |
| Elevation of legs | ☐ Y ☐ N | When? __________ |
| Medications for pain | ☐ Y ☐ N | Which? __________<br>How often? _______________ |
| Compression stockings<br>How long did you wear them?<br>Were they prescribed? | ☐ Y ☐ N<br>__________<br>☐ Y ☐ N | |
| **Does your leg pain/discomfort interfere with any of the following?** | | |
| Shopping | ☐ Y ☐ N | |
| Exercise | ☐ Y ☐ N | |
| Housework | ☐ Y ☐ N | |
| Sleeping | ☐ Y ☐ N | |
| Yard work | ☐ Y ☐ N | |
| Job duties | ☐ Y ☐ N | |
| Sitting | ☐ Y ☐ N | |
| Childcare | ☐ Y ☐ N | |
| Recreational activities | ☐ Y ☐ N | |
| Hiking/prolonged walking | ☐ Y ☐ N | |
| Other: ____________________ | ☐ Y ☐ N | |
| **How long have you had varicose veins?** | | |
| **When did you first develop symptoms?** | | |

| II. Family History | | |
|---|---|---|
| **Have any of your family members had:** | | |
| Varicose veins | ☐ Y ☐ N | Who?____________ |
| Vein stripping | ☐ Y ☐ N | Who?____________ |
| Blood coagulation disorders | ☐ Y ☐ N | Who?____________ |
| Blood clots | ☐ Y ☐ N | Who?____________ |
| Stroke, heart attacks, or pulmonary emboli | ☐ Y ☐ N | Who?____________ |

| III. Vein Treatment History | | |
|---|---|---|
| **Have you ever been treated for varicose veins with:** | | |
| Sclerotherapy | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Laser therapy (spider veins) | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Phlebectomy | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Vein stripping surgery | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Radiofrequency ablation (RFA) | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Radiofrequency laser ablation (EVLT) | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| VenaSeal Closure System | ☐ Y ☐ N | Leg: ☐ R ☐ L |
| Varithena | ☐ Y ☐ N | Leg: ☐ R ☐ L |

| IV. Personal/Activities List | | |
|---|---|---|
| Occupation? | | |
| Do you exercise? | ☐ Y ☐ N | How often? ___ |
| Are you following a weight loss/weight maintenance plan? | ☐ Y ☐ N<br>Which? __________________ | |
| Do you smoke? | ☐ Y ☐ N | # Per day? ____ |
| Prolonged sitting/standing? | ☐ Y ☐ N | |
| Pregnancies | ☐ Y ☐ N | How many? ___ |

## V. Location of Veins

Please mark the location of your varicose veins and areas of pain

RIGHT LEG — Anterior, Posterior

LEFT LEG — Anterior, Posterior

Patient Signature: ________________________________ Date: _____________