Venous Health History Form

Name: ____ Date: ___________________________

Age: __________________ Sex: M F

Referring Doctor/Primary Care Doctor: ____

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, which leg and when? ____

4. Have you ever had phlebitis? Yes No

   If yes, which leg and when? ____

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

Turn over please

Name: ____

Venous History

1. Do you experience any 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
i.	Other? ______________________________	Yes	No

Do you experience these problems in just one or both legs? Right Left Both

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

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

   If yes, what medication and how often? ______________________________

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

5. Do you have any problem walking? Yes No

   If yes, how does it affect you? ______________________________

6. Do you stand much at work? Yes No
   at home? Yes No

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

   If yes, when, what type test and where on the leg? ______________________________

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