



A. Venous Health History Form

Patient please complete questions 1-12

Patient Name: _____ Date of Birth: _____

Directions: Please answer the following questions. Provide estimates for date 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, 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? _____

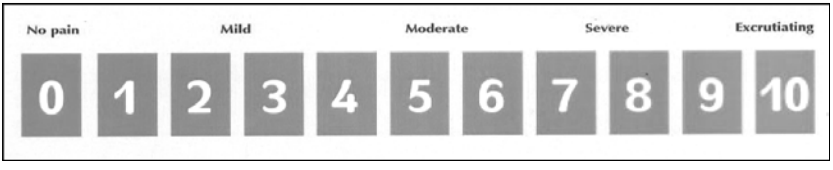
Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- | | | |
|------------|------------------------------|-----------------------------|
| Father | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

1. Do you experience any of the following in your legs?

Aching/pain?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Heaviness?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Tiredness/fatigue?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Itching/burning?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Swollen ankles?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Leg cramps?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Restless legs?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs
Throbbing?	<input type="checkbox"/> Yes	During activity or prolong standing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> LT / RT leg	<input type="checkbox"/> Both legs



- VAS Scale** -Rate the intensity of pain _____ Persistent Yes No
2. Have your veins gotten worse in recent months? Yes No
Describe: _____
 3. Do you take any medication for pain (i.e., Advil, Motrin) Yes No
If yes, what medication(s) do you take and how many times/mgs per day? _____

4. Do you elevate your legs to relieve discomfort? Yes No
If yes, how long per day do you elevate and does it provide relief? _____

Venous Health History Form (cont.)

5. Do you exercise? Yes No
If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? Yes No
If yes, what type and gradient? How long have you worn them? _____

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)? Yes No
If yes, do they provide relief? _____

8. Do you have any problem walking? Yes No
If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise) _____

9. What type of work do you do? _____
How long do you stand (hours per day) at work? _____ At home? _____
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours) _____

10. Have you ever had any test(s) done on your veins? Yes No
If yes, when and what type of test and where on the leg? _____

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

12. Name of referring Physician and how long have you been under his care for treatment of this condition? _____

Patient Signature: _____ Date: _____

PATIENTS: Please stop here. The physician may go over additional questions with you.