

**Venous Medical History**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Who Referred you to us today? Self \_\_\_\_\_ or Physicians name: \_\_\_\_\_**

Phone: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Primary Physician \_\_\_\_\_

Reason you are seeking treatment for your veins: \_\_\_\_\_

Please circle any symptoms that you have in your legs:

**Swell    Ache    Red and Inflamed                      Bulging Veins Cramp    Burn/Itch    Restless Legs**

How long have you had your symptoms? \_\_\_\_\_

Do your symptoms negatively impact your daily activities?                       **Yes**     **No**

Do your symptoms negatively impact your ability to perform your occupation?                       **Yes**     **No**

Are your veins getting worse?  **Yes**     **No**    Is one leg worse than the other? **R>L** or **L>R** or **L=R**

Have you ever had treatment of your veins?  **Yes**     **No**    If yes, Where? \_\_\_\_\_

And what type of treatment? \_\_\_\_\_

Have you ever worn compression hose?  **Yes**     **No**    If Yes, How long? \_\_\_\_\_ Did they help?  **Yes**     **No**

Do you have children?  **Yes**     **No**    If yes, How many and what are their ages? \_\_\_\_\_

For female patients: Did your veins develop during a pregnancy?  **Yes**     **No**    Do you suffer from hemorrhoids?  **Yes**     **No**

Did you experience labial varicosities during your pregnancies?     **Yes**     **No**

Has anyone in your family had a history of varicose veins?     **Yes**     **No**    If Yes, Who? \_\_\_\_\_

Have you ever been treated for a blood clot in your legs?  **Yes**     **No**    If Yes, Which leg?    **L**    **R**

Have you ever had an ulcer on your legs?  **Yes**     **No**    If Yes, Which leg?    **L**    **R**

Do you have any congenital heart conditions?  **Yes**     **No**    If yes, Please explain: \_\_\_\_\_

Please circle any of the following medical problems you have:

**High Blood Pressure                      Heart Disease                      Lung Disease                      Liver Disease**  
**Peripheral Vascular Disease                      Thrombophilia                      Cancer                      Diabetes**

Please list any pertinent medical conditions you have that are not listed above:

\_\_\_\_\_  
\_\_\_\_\_

Medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any blood thinners or Aspirin?  Yes  No If Yes, Why? \_\_\_\_\_

Please list any allergies you have: \_\_\_\_\_

\_\_\_\_\_

Please list any previous surgeries and dates: \_\_\_\_\_

\_\_\_\_\_

Have you ever smoked?  Yes  No If yes, for how long? \_\_\_\_\_

If you quit smoking, how long has it been since you quit? \_\_\_\_\_

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

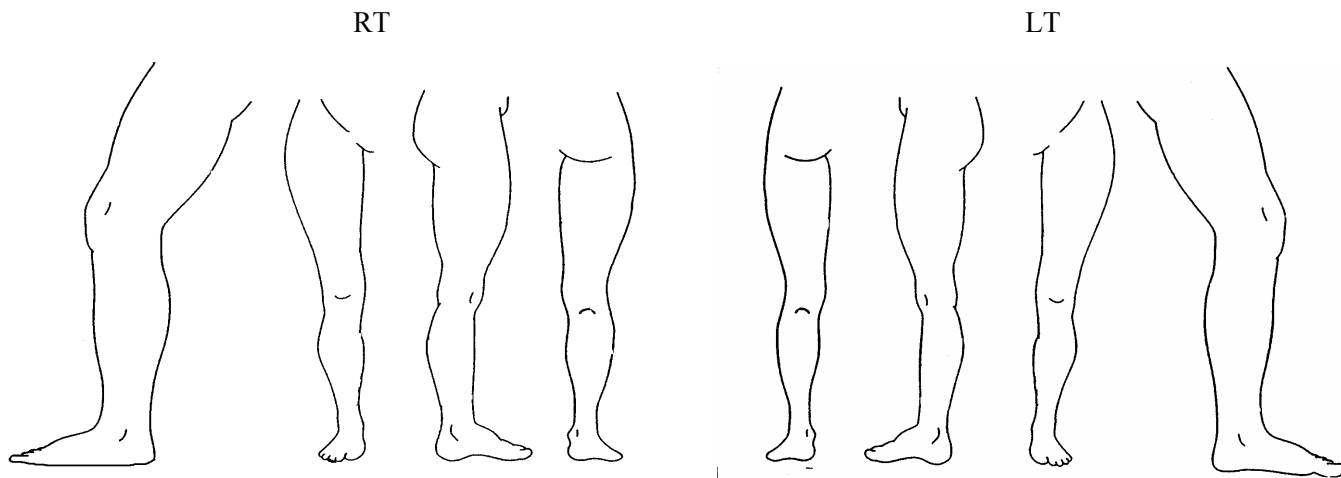
**Remainder to be filled out by Technicians**

**BP:** \_\_\_\_\_ / \_\_\_\_\_ mmHg **Pulses: DP** \_\_\_\_\_ **PT** \_\_\_\_\_

**Capillary Refill**    **Muscle Strength**    **Lipodermatosclerosis**    **Ulcers**    **Dermatitis**

**Physical Findings:** \_\_\_\_\_

**Additional work-up required:** \_\_\_\_\_



Thigh \_\_\_\_\_ Calf \_\_\_\_\_ Ankle \_\_\_\_\_                      Thigh \_\_\_\_\_ Calf \_\_\_\_\_ Ankle \_\_\_\_\_

Interviewer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_