



IMAGE NORTH

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: _____

How long have you had the veins you are concerned about? _____

Please circle any symptoms that you have in your legs:

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

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**

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

Do you suffer from hemorrhoids? **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? _____

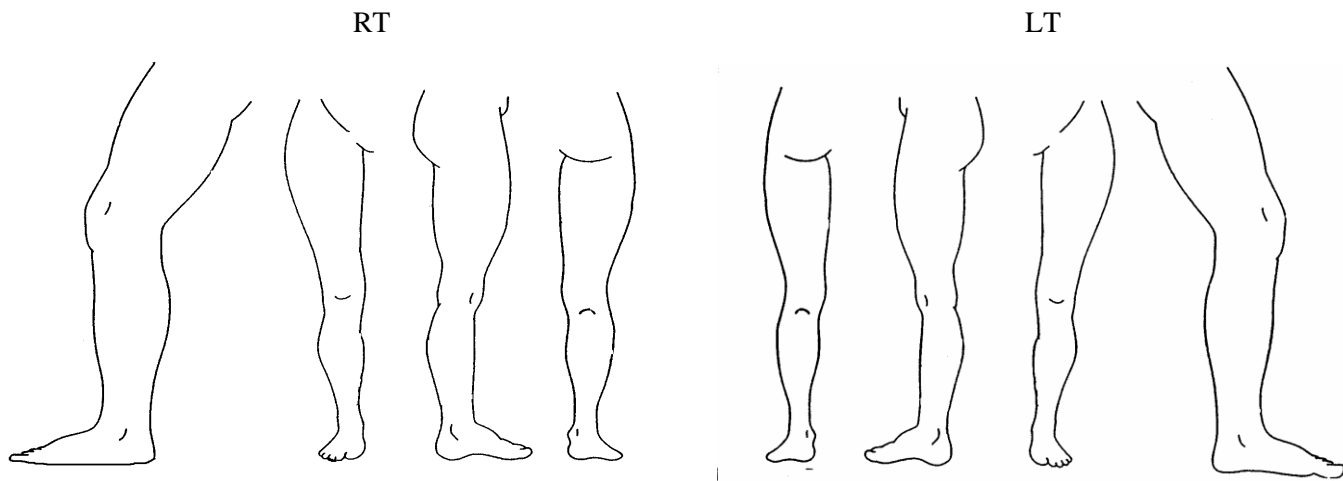
Remainder to be filled out by Technicians

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: _____