NAME:

Address:

DOB:

Varicose Vein History

DO YOU HAVE in YOUR LEGS …(please circle which leg and problem)

R L bulging veins
R L spider veins
R L ankle / leg swelling
R L skin color changes
R L rashes
R L red warm thickened skin
R L skin ulcers

R L aching / throbbing
R L tired / heavy legs
R L burning or pain in leg
R L itching
R L hurts to touch/squeeze
R L restless legs syndrome
R L night cramps

R L crawling sensation
R L leg numbness/tingling

Veins of Vulva or Scrotum or upper inner thighs?

How far can you walk before stopping due to your legs?
______________Yards/Miles

WHICH LEG IS AFFECTED THE MOST? **Right** **Left** **Both Equally**

PERSONAL HISTORY OF VEINS:

# of years you have had trouble with your legs: ______

Are your veins related to pregnancy	yes	no
Are you developing new veins	yes	no
Are your legs getting worse	yes	no
Are you pregnant or nursing:	yes	no
Are you planning more children	yes	no

Are your symptoms worse with:

Menstrual Cycle	yes	no
Standing	yes	no
Walking	yes	no
Sitting	yes	no
Nighttime/Laying down	yes	no

Did you ever smoke Yes No If YES, When did you Quit? ______ Do you have children? YES NO

Are you supposed to take antibiotics before dental or surgical procedure due to heart valve problems or implanted metal in your body (knee or hip replacement)? Yes No

PAST MEDICAL HISTORY: (circle if you have ever had) Asthma Diabetes

Heart disease/surgery Stroke Migraines PAD (clogged arteries in legs)
Heart murmur Phlebitis Blood clots Pulmonary embolus
Bleeding /Clotting disorder High blood pressure Neuropathy Back pain/Sciatica

OTHER MEDICAL / SURGICAL HISTORY: (list all MEDICAL PROBLEMS and Surgeries and year**)**

____

____

____

Name: **DOB:**

Continued: ____

____

MEDICATIONS/ Vitamins, Supplements you are currently taking:_______________________________

____

____

ALLERGIES to any medications: ____

Are you Sensitive /Allergic to: Novocain, Lidocaine, Iodine, Betadine, Adrenaline, Epinephrine or latex?

OCCUPATION: ____

FAMILY HISTORY of varicose veins or **blood clots**: Mother Father Siblings Grandparents

PREVIOUS VEIN TREATMENT HISTORY: (circle all that apply)

Ligation / Stripping / Laser Surgery If so, which leg: R L When? ________________
How successful was the treatment? ________________

Vein Injection treatments If so, which leg: R L When? _________________
How successful was the treatment? ________________

How Did You Find Us or Who Referred You?____

Who are your Personal Physicians: ____

Patient Signature: __________________________________ Date _____________________

For Office Use Only:

PREVIOUS CONSERVATIVE TREATMENTS TRIED:

Have you **EVER** worn compression (support) hose to help with your legs? Yes No

When? ________________________ How Long? _____________

Did they **help** with your symptoms (pain, aching, swelling)? Totally Partially No

Do pain medications help with your leg pain/veins? Totally Partially No
Which meds?_____________________________

Are your symptoms relieved with rest/elevation of legs? Totally Partially No

Reviewer:____ Date______________________

For Office Use Only:

PREVIOUS CONSERVATIVE TREATMENTS TRIED:

How do your legs bother you or interfere with activities of daily living?

Activities interfered with: Standing Sitting Walking Running Exercise Stairs

Other:____

____

Activities that require prolonged periods of standing and How LONG do you have to stand?

____

How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities? (PRIOR to compression)

Never (0) Once per day (1) 2-3 times per day (2) 4 or more times per day (3)

Do you take OTC or Rx medications for aching, cramping, burning or swelling of the lower extremities?

YES NO

What is the medication and dosage?____

How many days in a 2-week period of time do you take the medication? (PRIOR to compression)

0-2 Days (0) 3-4 Days (1) 5-6 Days (2) 7 or more days (3)

Have you completed a trial of compression stockings?

YES NO

Strength of stockings: TEDs Class I (20-30mm) <u>Class II (30-40mm)</u> Class III (40-50)

When?________________________________ How long?__________________________

Did the trial result in a significant improvement in symptoms? YES NO

Scale: 0 = no symptoms 1 = mild 2 = moderate 3 = severe

Are your symptoms relieved with rest /elevation of legs? Partially / totally yes no

Reviewer:____ Date______________________