Venous History Form

<u>Please complete all pages to the best of your knowledge</u>

Name: ____ **DOB**: __________________

Primary Physician: ____
Facility Location:____
Referring Physician: ____
Facility Location:____

Which leg/s are you seeking treatment for: ☐ right ☐ left ☐ both

Symptoms (mark all that apply):

☐ Pain ☐ Varicose veins ☐ Pelvic pain
☐ Heaviness ☐ Spider veins ☐ Painful intercourse
☐ Burning/itching ☐ Skin discoloration ☐ Other ________________________________
☐ Swelling ☐ Restless leg syndrome

How long have you had symptoms: ____

Have you ever been told or been diagnosed with:

Phlebitis ☐yes ☐no When _____________________________
Blood clot in leg/s ☐yes ☐no When ______________________________
Were you treated or are you being treated with blood thinners: ☐yes ☐no
When:__________________ How long:_______________
What was the blood thinner: _______________________
Skin sores/ulcers ☐yes ☐no
When did sore/ulcer first appear ____
How long did it take to heal ____
Treatments used to aide the healing ____

What makes symptoms worse? (check all those that apply)

☐ Prolonged standing ☐ Walking/exercise ☐ Menstrual periods
☐ Prolonged sitting ☐ Sleeping ☐ Pregnancy (year/s) _______________________
☐ Other _______________________________________

On average, how much of the day do you spend on your feet? ___________________________

What activities(s) require prolonged standing? _____________________________

What makes symptoms better or what therapy have you tried?

Leg elevation ☐yes ☐no How many times per day ______________
Medications (Tylenol, advil, motrin, aspirin, etc.) ☐yes ☐no
How often per week ___________ Dosage __________________
Weight loss ☐yes ☐no
Exercise ☐yes ☐no What kind of exercise: __________________________________
Stockings ☐yes ☐no ☐ over the counter ☐ prescription
What strength of prescription: ☐ 20-30mmHg ☐ 30-40mmHg
How long have you worn stockings: ____

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Explain in detail how your symptoms affect your daily activities:

____
____
____

Prior vein treatments ❑YES ❑NO
☐ Stripping/Surgery (dates) ______________________ ☐ Ablation (dates) ______________________
☐ Injections (dates) ____

Family History:
Varicose Veins ❑ yes ❑ no If yes who ______________________________________
Clotting problems ❑ yes ❑ no If yes what is the problem ______________________________
Any other information that you feel may be important for us to know?

____
____

Education completed: ______________________ Military history: ______________________________

Medical History (all categories require a response):

Condition			Condition		
Stroke	☐yes	☐no	TIA/mini stroke	☐yes	☐no
Seizures	☐yes	☐no	Neurologic disorder	☐yes	☐no
Heart attack	☐yes	☐no	High blood pressure	☐yes	☐no
"Hole in heart"/ASD	☐yes	☐no	Murmur/extra heart sounds	☐yes	☐no
Irregular heart beat	☐yes	☐no	Peripheral arterial disease	☐yes	☐no
IVC filter	☐yes	☐no	Blood clot in lungs	☐yes	☐no
Smoker	☐yes	☐no	Lung disease	☐yes	☐no
Stomach ulcer	☐yes	☐no	Gastritis	☐yes	☐no
Indigestion/GERD	☐yes	☐no	Kidney disease	☐yes	☐no
Liver disease/hepatitis	☐yes	☐no	Bleeding disorder	☐yes	☐no
Arthritis	☐yes	☐no	Diabetes	☐yes	☐no
HIV/AIDS	☐yes	☐no	Cancer	☐yes	☐no
Pregnancies	☐yes	☐no	Planning on future pregnancies	☐yes	☐no

Surgeries/Procedures/Hospitalizations:

____
____
____

Tobacco ☐ yes ☐ no Amount ______________________________
Alcohol ☐ yes ☐ no Amount ______________________________
Caffeine ☐ yes ☐ no Amount ______________________________

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Allergies/Sensitivities	Reaction

Please list all medications (including over-the-counter, vitamins, supplements, etc.)

Name of medication	Dose/Strength	Frequency (how often you take it)	Route (pill, liquid, powder, etc)

Reviewed:____

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