Venous History Form

Please complete patient section to the best of your knowledge

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 with ☐standing ☐sitting ☐activity
☐ 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 ever treated or are you currently being treated with blood thinners: ☐yes ☐no
When:_____ How long:_____
Name of 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 _____

How much of the day do you spend on your feet _____

What activities 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 or exercise: _____
Have you worn stockings ☐yes ☐no How long _____
Prescription ☐yes ☐no Stocking strength: ☐ 20-30mmHg, ☐ 30-40mmHg, ☐ other: _____

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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?
_____

History (all categories require a response):

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
			Most recent mammo date_____		

Social History

Smoker	☐yes	☐no	pack/cigarettes per day: _____	
Alcohol	☐yes	☐no	how often: _____	amount: _____
Caffeine	☐yes	☐no	cups per day: _____	
Education: _____			Military service: _____	

Surgeries/Procedures/Hospitalizations: _____
_____
_____

Office Staff/Physician to fill in

CC:_____
_____

Temp _____ BP _____ RR _____ HR _____ Oxim _____ Wt _____ Ht _____

ROS: ☐fever ☐chills ☐weight loss/gain ☐fatigue ☐headaches ☐numbness/tingling ☐weakness ☐edema ☐chest pains ☐palpitations ☐cough ☐congestion ☐shortness of breath ☐snoring ☐abd pain ☐rash ☐skin sores ☐easy/unusual bruising

Notes:_____

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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: _____