



## PATIENT VENOUS HISTORY

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

- |   |            |          |
|---|------------|----------|
| 1. Have you had any previous treatment for varicose/spider veins?<br>Date(s) of treatment _____<br>Type of agent(s) used if known _____ | YES        | NO       |
| 2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis?   | YES        | NO       |
| 3. Do you have a family history of varicose/spider veins?<br>If so, relationship(s) to you? _____                                       | YES        | NO       |
| 4. Are you currently, or have you been on any hormone therapy or birth control pills?<br>If so, please list _____                       | YES        | NO       |
| 5. Have you had any pregnancies? If so, how many? _____<br>If so, did your varicose/spider veins increase after your pregnancies?       | YES<br>YES | NO<br>NO |
| 6. Do you wear support hose?<br>If yes, are they prescription or over-the-counter?  | YES<br>RX  | NO<br>OC |
| 7. Are you presently employed? If so, type of job _____   | YES        | NO       |
| 8. Do you sit or stand for long periods of time? How many hours per day? _____  | YES        | NO       |
| 9. Do you take any pain medication for your varicose/spider veins (Aspirin/Tyelonol)  | YES        | NO       |
| 10. Do you elevate your legs to relieve your symptoms?<br>If so, does it work?  | YES<br>YES | NO<br>NO |
| 11. Do you have any medication allergies? If so, please list _____  | YES        | NO       |

Additional History \_\_\_\_\_  
\_\_\_\_\_

### COMPREHENSIVE HISTORY CHECK LIST (please check all that apply)

	Right Leg	Left Leg
Edema	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Ulceration	<input type="checkbox"/>	<input type="checkbox"/>
Skin Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Spider Veins	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_