# THE VASCULAR GROUP PLLC

## Venous Health History Form

**Patient please complete questions 1-12**

**Patient Name:** _____ **Date of Birth:** _____

**Directions: Please answer the following questions. Provide estimates for date of occurrence.**

**Past Medical History**

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? _____

2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____

3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____

4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

5. Have you ever had leg ulcers? ☐ Yes ☐ No
   If yes, which leg and when? _____

6. Have you ever had bleeding from varicose veins? ☐ Yes ☐ No
   If yes, which leg and when? _____

**Family History**

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

| | | |
|---|---|---|
| Father | ☐ Yes | ☐ No |
| Mother | ☐ Yes | ☐ No |
| Brother(s) | ☐ Yes | ☐ No |
| Sister(s) | ☐ Yes | ☐ No |
| Other | ☐ Yes | ☐ No |

1. Do you experience any of the following in your legs?

| | | | | |
|---|---|---|---|---|
| Aching/pain? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Heaviness? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Tiredness/fatigue? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Itching/burning? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Swollen ankles? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Leg cramps? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Restless legs? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |
| Throbbing? | ☐ Yes | ☐ No | ☐ One leg | ☐ Both legs |

   Other?_____

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____

3. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication do you take and how many times/mgs per day? _____
   _____

**Venous Health History Form (cont.)**

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief? _____
   _____

5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
   **If yes, what type and gradient? How long have you worn them**? _____
   _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)? ☐ Yes ☐ No
   If yes, do they provide relief? ☐ Yes ☐ No

8. Do you have any problem walking? ☐ Yes ☐ No
   If yes, describe how it interferes with your activities of daily living, which activities? _____
   _____

9. What type of work do you do? _____
   How long do you stand (hours per day) at work? _____ At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: _____
   _____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
    If yes, when and what type of test and where on the leg? _____
    _____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?
    _____

Patient Signature: _____Date:_____

**PATIENTS: Please stop here. The physician may go over additional questions with you.**

**PHYSICIAN TO COMPLETE BELOW THIS POINT**

**PHYSICIAN TO COMPLETE**

Physician Additional Comments: _____

_____

_____