

## VEIN HEALTH & HISTORY FORM

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Last First M.I.

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Are you requesting a vein evaluation for medical reasons? Yes No

What is your chief complaint (primary vein concern)? \_\_\_\_\_

Indicate whether you are Now or Before experiencing any of the following vein symptoms: (circle all that apply)

Now : Before \_\_\_\_ : \_\_\_\_ I deny experiencing any of the vein symptoms listed below

Now : Before \_\_\_\_ : \_\_\_\_ burning / itching / tingling / heaviness / fatigue / pain / discomfort / cramping

Now : Before \_\_\_\_ : \_\_\_\_ generalized leg swelling / ankle swelling / restlessness in the legs

Now : Before \_\_\_\_ : \_\_\_\_ worsening leg veins / bulging leg veins / pelvic area bulging or varicose veins

Now : Before \_\_\_\_ : \_\_\_\_ phlebitis (vein tenderness) / leg ulcers / blood clots / ruptured or bleeding veins

Now : Before \_\_\_\_ : \_\_\_\_ deep vein thrombosis (DVT) / pulmonary embolism (PE)

Do you have a family history of vein disease? Yes No Any family history of blood clots? Yes No

Have you ever smoked tobacco? Yes No Have you ever had a substance abuse problem? Yes No

Are you currently working? Yes No What is your occupation: \_\_\_\_\_

Are you required to sit/stand for prolonged periods? Yes No Do you walk during your job? Yes No

How long ago did your vein problem first begin? \_\_\_\_\_

If you have worn compression stockings before, please indicate for how many months or years? \_\_\_\_\_

What relieves your vein symptoms? \_\_\_\_\_ Don't know

What makes your vein symptoms worse? \_\_\_\_\_ Don't know

Have you been previously evaluated for a vein problem? Yes No Explain: \_\_\_\_\_

Indicate which prior vein treatments you have had: (check all that apply) \_\_\_\_ no prior vein treatments

\_\_\_\_ sclerotherapy injections      \_\_\_\_ surgical ligation      \_\_\_\_ surgical vein stripping

\_\_\_\_ ambulatory phlebectomy      \_\_\_\_ surface laser/light      \_\_\_\_ endovenous laser ablation

\_\_\_\_ radiofrequency closure      \_\_\_\_ other: \_\_\_\_\_

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List your current medications: \_\_\_\_\_

Do you have any medication allergies? Yes No Explain: \_\_\_\_\_

Do you have a latex allergy? Yes No Explain: \_\_\_\_\_

List prior surgeries: \_\_\_\_\_

List prior hospitalizations: \_\_\_\_\_

List medical conditions you are being treated for: \_\_\_\_\_

Indicate which of the following conditions below which you have had (check those that apply): \_\_\_\_\_ None

- |                                  |                                   |                               |
|----------------------------------|-----------------------------------|-------------------------------|
| _____ blood clotting disorder    | _____ anemia or bleeding disorder | _____ heart defect or PFO     |
| _____ migraine headache          | _____ high blood pressure         | _____ heart murmur            |
| _____ asthma or lung disease     | _____ stroke or CVA               | _____ diabetes mellitus       |
| _____ coronary artery disease    | _____ peripheral artery disease   | _____ renal or kidney disease |
| _____ hepatitis or liver disease | _____ joint replacement surgery   | _____ cancer or malignancy    |
| _____ HIV/AIDS                   | _____ hypercholesterolemia        | _____ other: _____            |

**For Women Only**

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_ Ages of children: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_ Are you pregnant or planning to get pregnant? Yes No

Do you have any pelvic area varicose veins? Yes No \_\_\_\_\_

Do you commonly experience pain with intercourse? Yes No \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_ Date Signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Signature: \_\_\_\_\_

 \_\_\_\_\_  
 RVT Signature Date Physician Signature Date