

**VEIN HEALTH & HISTORY FORM**

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

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Are you requesting evaluation at HVI for medical reasons? Yes No

What is your chief medical concern? \_\_\_\_\_

Indicate whether you have ever experienced any of the following: (check all that apply)

- burning/itching/tingling       heaviness/fatigue       pain/discomfort/cramping
- generalized leg swelling       ankle swelling       restlessness in your legs
- worsening leg veins       bulging leg veins       phlebitis (vein inflammation)
- leg ulcers or sores       deep vein thrombosis       trauma or surgery

Do you have a family history of vein disease? Yes No Which relatives? \_\_\_\_\_

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

Are you currently working? Yes No Occupation: \_\_\_\_\_

Are you required to sit or stand for prolonged periods? Yes No For how long? \_\_\_\_\_

When did your vein problem first start? \_\_\_\_\_

Have you worn compression stockings before? Yes No For how long? \_\_\_\_\_

What relieves your vein symptoms? \_\_\_\_\_

What makes your vein symptoms worse? \_\_\_\_\_

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

Indicate which prior vein treatments you have had: (check all that apply)

- sclerotherapy injections       surgical ligation       surgical vein stripping
- ambulatory phlebectomy       surface laser/light       endovenous laser ablation
- radiofrequency closure       other: \_\_\_\_\_

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

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

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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 Medical Conditions you have ever had: (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> blood clotting disorder        | <input type="checkbox"/> anemia or bleeding disorder | <input type="checkbox"/> PFO or heart defect     |
| <input type="checkbox"/> migraine headaches             | <input type="checkbox"/> high blood pressure         | <input type="checkbox"/> diabetes                |
| <input type="checkbox"/> asthma or lung disease         | <input type="checkbox"/> pulmonary embolism          | <input type="checkbox"/> deep vein thrombosis    |
| <input type="checkbox"/> phlebitis or vein inflammation | <input type="checkbox"/> vein rupture (bleeding)     | <input type="checkbox"/> stroke or CVA           |
| <input type="checkbox"/> coronary artery disease        | <input type="checkbox"/> peripheral artery disease   | <input type="checkbox"/> renal or kidney disease |
| <input type="checkbox"/> hepatitis or liver disease     | <input type="checkbox"/> joint replacement surgery   | <input type="checkbox"/> cancer or malignancy    |
| <input type="checkbox"/> HIV/AIDS                       | <input type="checkbox"/> 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 pelvic or vulva or labial area varicose veins?    Yes    No    Explain: \_\_\_\_\_

Do you commonly experience pain with intercourse?    Yes    No

Patient or Responsible Party Signature: \_\_\_\_\_

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

RVT Signature	Date	Physician Signature	Date