# Vein History

Name:______________________________ Age: __________ DOB: __________ Date: ____________

Did your physician refer you to the Vein Clinic? ❐ Did you refer yourself? ❐

Length of symptoms? ________________ # months ____________ # years

## Symptoms:

*PLEASE CHECK ALL THAT APPLY TO YOU*

| Symptom | | | | Condition | |
|---|---|---|---|---|---|
| Aching / pain in legs | ❐ Right | ❐ Left | ____________ | Heart Disease | ❐ |
| Heaviness | ❐ Right | ❐ Left | ____________ | Contagious Disease | ❐ |
| Tiredness/fatigue | ❐ Right | ❐ Left | ____________ | Hepatitis | ❐ |
| Itching/Burning | ❐ Right | ❐ Left | ____________ | High Blood Pressure | ❐ |
| Leg Cramping | ❐ Right | ❐ Left | ____________ | Diabetes | ❐ |
| Leg Restlessness | ❐ Right | ❐ Left | ____________ | Cancer | ❐ |
| Throbbing | ❐ Right | ❐ Left | ____________ | Lupus | ❐ |
| Swelling | ❐ Right | ❐ Left | ____________ | Leg Trauma/Surgery | ❐ |
| Night Cramps | ❐ Right | ❐ Left | ____________ | Major Surgery/Hospitalizations | ❐ |
| Discoloration | ❐ Right | ❐ Left | ____________ | Bleeding or Clotting Disorder | ❐ |
| Bleeding from a vein? | ❐ Right | ❐ Left | ____________ | | |
| Ulcerations | ❐ Right | ❐ Left | ____________ | | |

*If ulcerations, where were they and have they healed?*______________________________

______________________________________________

**Please be <u>very specific</u> with your answers below:**

Do your symptoms interfere with your sleep? ❐ Yes ❐ No

How? ______________________________________________

______________________________________________

Do your symptoms interfere with walking? ❐ Yes ❐ No

How? ______________________________________________

______________________________________________

Do your symptoms worsen with or after activity? ❐ Yes ❐ No

How? ______________________________________________

______________________________________________

Do your symptoms affect work or interfere with your job? ❐ Yes ❐ No

How? ______________________________________________

______________________________________________

Do your symptoms affect lifestyle such as maintaining healthy weight? ❐ Yes ❐ No

How? ______________________________________________

______________________________________________

Additional Notes: ______________________________________________

______________________________________________

______________________________________________

Name: ______________________________ DOB:__________

## Conservative Treatment:

What conservative measures have you used or are currently using to help with the symptoms of your varicose veins?

❒ Pain medication (ibuprofen,etc) ❒ Herbal supplements ❒ Job Change
❒ Leg elevation ❒ Exercise ❒ Weight loss
❒ Compression stockings 20-30 mmHg ❒ Other compression: ______________________________

Are you currently using compression stockings? ❒ Yes ❒ No If yes, how long? ________________
Have you worn compression stockings in the past? ❒ Yes ❒ No If yes, how long?________________

Are any of the above helpful? ❒ Not at all ❒Slightly ❒Significantly ❒ Completely resolved my symptoms

## Restless Leg Syndrome:

Do you find the need to move your legs to relieve an uncomfortable feeling? ❒ Yes ❒ No
Do your legs feel better when moving them or walking? ❒ Yes ❒ No
Are your legs worse when sitting or resting? ❒ Yes ❒ No
Are your leg symptoms worse later in the day or at night? ❒ Yes ❒ No

## Women Only:

Are you pregnant or considering a pregnancy sometime in the future? ❒ Yes ❒ No
Are you breast-feeding? ❒ Yes ❒ No Are your legs more painful associated with menstruation? ❒ Yes ❒ No
Have you been diagnosed with Pelvic Congestion Syndrome? ❒ Yes ❒ No
Pain with and after intercourse? ❒ Yes ❒ No Frequent and sudden need to urinate? ❒ Yes ❒ No
Number of pregnancies? __________ Number of deliveries? ____________ Age(s) of Children:____________________

## Additional Information

***Please check box if you have, or have had, any of the following:***

A prior evaluation for your veins? ❒ Yes ❒ No
Previous vein surgery or laser treatment? ❒ Yes ❒ No
Previous vein injections? ❒ Yes ❒ No
Have you ever had Venaseal? ❒ Yes ❒ No
Have you ever had thermal ablation? ❒ Yes ❒ No

A family history of vein disease? ❒ Yes ❒ No
If yes, who? ______________________________
A family history of leg ulcerations? ❒ Yes ❒ No
If yes, who? ______________________________
A family history of blood clots in the leg(s)❒ Yes ❒ No
If yes, who? ______________________________