Venous History

Please answer the following questions.

Past Medical History – provide estimates for date of occurrence

1. Have you ever had vein stripping? ___ Yes ___ No When _____
2. Have you ever had vein injections? ___ Yes ___ No When _____
3. Have you ever had a blood clot? ___ Yes ___ No When _____
4. Have you ever had a pulmonary embolism? ___ Yes ___ No When _____
5. Have you ever had phlebitis? ___ Yes ___ No When _____
6. Bleeding varicose veins? ___ Yes ___ No When _____
7. Have you ever had migraines? ___ Yes ___ No When _____

Family History

Does anyone in your family have a history of blood clots, pulmonary embolism? ___ Yes ___No

Are you currently pregnant or breast-feeding? ___Yes ___ No

Current Vein History

Do you experience any of the following symptoms that interfere in activities of daily living?

Aching/pain	___ Right	___ Left
Heaviness	___ Right	___ Left
Tiredness/fatigue	___ Right	___ Left
Itching/burning	___ Right	___ Left
Swelling/edema	___ Right	___ Left
Restless legs	___ Right	___ Left
Bleeding	___ Right	___ Left
Sores/Ulcers	___ Right	___ Left

Do your symptoms interfere in your activities of daily living? ___Yes ___ No

What pain medication have you taken for relief of symptoms?

___ Aspirin ___ Ibuprofen ___ Aleve ___ Tylenol ___ Other _____

Does elevation relieve your leg symptoms? ___ Yes ___ No

What else have you tried to improve your symptoms?

___ Exercise ___ Weight loss ___ Compression stockings How long _____