



NAME:

Address:

DOB:

### Varicose Vein History

**DO YOU HAVE...(please circle which leg and problem)**

|                          |                  |                            |                         |
|--------------------------|------------------|----------------------------|-------------------------|
| R L aching / throbbing   | R L leg pain     | R L tenderness in legs     | R L burning pain in leg |
| R L night cramps         | R L itching      | R L red or warm areas      | R L tired / heavy legs  |
| R L bulging veins        | R L hard lumps   | R L skin changes in legs   | R L skin ulcers         |
| R L ankle / leg swelling | R L spider veins | R L restless legs syndrome | R L other: _____        |

**PERSONAL HISTORY OF VEINS:**

Number of years of you have had trouble with your veins: \_\_\_\_\_

Are your Veins related to: pregnancy yes no  
 accident yes no  
 Are you developing new veins yes no  
 Are your veins getting worse yes no  
 Do your leg symptoms interfere with your daily activities yes no  
 Do you smoke yes no  
 Are you planning to have more Children yes no  
 Are you pregnant or nursing: yes no  
 Number of biological children \_\_\_\_\_

**Are your symptoms worse with:**  
 prolonged standing yes no  
 prolonged sitting yes no  
 menstrual cycle yes no

**Are your symptoms relieved with:**  
 rest /elevation of legs yes no

**Have you been told to take antibiotics before dental or surgical procedures?** yes no

**PAST MEDICAL HISTORY:** (circle if you have ever had)

|                       |                       |             |           |                  |
|-----------------------|-----------------------|-------------|-----------|------------------|
| High blood pressure   | Heart disease/surgery | HIV         | Hepatitis | Arterial disease |
| Mitral valve prolapse | Bleeding disorder     | Stroke      | Seizures  | Heart murmur     |
| Pulmonary embolus     | Phlebitis             | Blood clots | Diabetes  | Migraines        |

**OTHER MEDICAL HISTORY:** (list all MEDICAL PROBLEMS and year) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SURGICAL HISTORY:** (list all surgeries and year) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS** you are currently taking: \_\_\_\_\_

\_\_\_\_\_

**Name:**

**DOB:**

**ALLERGIES** to any medications: \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_

**FAMILY HISTORY** of varicose or spider veins or **blood clots:**

Mother      Father      Siblings      Grandparents

**PREVIOUS TREATMENT HISTORY:** (circle all that apply)

Ligation / Stripping Surgery    If so, which leg:      R      L      When? \_\_\_\_\_  
How successful was the treatment? \_\_\_\_\_

Injection treatments              If so, which leg:      R      L      When? \_\_\_\_\_  
How successful was the treatment? \_\_\_\_\_

Laser Treatments                    If so, which leg:      R      L      When? \_\_\_\_\_  
How successful was the treatment? \_\_\_\_\_

**Who is your Family Physician:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_      **Date** \_\_\_\_\_

**For Office Use Only:**

**PREVIOUS CONSERVATIVE TREATMENTS TRIED:**

Have you **EVER** worn compression (support) hose to help with your veins?  
When? \_\_\_\_\_      yes      no

Did they **help** with your symptoms (pain, ache, swelling)? Partially / totally      yes      no

Do you take pain medications to help with your leg pain/veins?      yes      no  
What meds? \_\_\_\_\_

Are your symptoms relieved with rest /elevation of legs?      yes      no

**Reviewer:** \_\_\_\_\_      **Date** \_\_\_\_\_