

Name:

DOB:

SURGICAL HISTORY: (list all surgeries and year) _____

MEDICATIONS you are currently taking: _____

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 Physicians: _____

Patient Signature: _____ **Date** _____

Name:

For Office Use Only:

DOB:

PREVIOUS CONSERVATIVE TREATMENTS TRIED:

How do your legs bother you or interfere with activities of daily living?

Activities interfered with: Standing Sitting Walking Running Exercise Stairs

Other: _____

Activities that require prolonged periods of standing and How LONG do you have to stand?

How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities? (PRIOR to compression)

Never (0) Once per day (1) 2-3 times per day (2) 4 or more times per day (3)

Do you take OTC or Rx medications for aching, cramping, burning or swelling of the lower extremities?

YES NO

What is the medication and dosage? _____

How many days in a two week period of time do you take the medication? (PRIOR to

compression) 0-2 Days (0) 3-4 Days (1) 5-6 Days (2) 7 or more days (3)

Have you completed a trial of compression stockings?

YES NO

Strength of stockings: TEDs Class I (20-30mm) Class II (30-40mm) Class III (40-50)

When? _____ How long? _____

Did the trial result in a significant improvement in symptoms? YES NO

Scale: 0 = no symptoms 1 = mild 2 = moderate 3 = severe

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

Reviewer: _____

Date _____