

Vein/Leg Health History Form

Patient Name: _____

Today's Date: _____

1. Are we examining your Right Leg Left Leg Both Legs
2. Have you had any previous vein procedures? Yes No
 - a. If yes, which procedure(s)? Spider Vein Injections Vein Stripping Vein Ablation
 Microphlebectomy Other _____
3. How many years have you suffered from Varicose or Spider Veins? _____
4. Do you have or have you had any of the following:

Unsightly Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Pigmentation (discoloration)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Dermatitis (eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Aches or Pain in the legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Heaviness or tired legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Itching in legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Night Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Blood clots (requiring blood thinners)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Superficial Phlebitis (clots in surface veins)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Pulmonary Emboli (blood clots in lungs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Swelling in the legs or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Ulcerations on the leg	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
Recent or Remote Leg Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left

5. Do you have family history of Varicose Veins? Yes No
6. What activities cause more pain or discomfort? _____
7. What brings you relief? _____
8. Have you had any recent ultrasounds of the leg? Yes No
If Yes, When and Where: _____
9. Are you unable to perform specific activities due to these problems? Yes No
If Yes, Please list: _____
10. Most insurance companies require documentation of treatments tried when considering coverage for vein procedures. This includes compression stockings and medications and elevating the legs. Please complete the following. Include over the counter and prescriptions.
 - a. Medications:
 Tylenol Ibuprofen Aspirin Other _____
 - b. Compression Stockings:
 Knee High Thigh High Full Hose Compression Grade if known: _____
 - c. Elevating your legs when resting:
 Yes No How Often _____