



## Total Vein Care Patient History Form

Name \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Female Male

**Directions: Please answer the following questions. Provide estimates for the date of occurrence.**

Did a physician refer you?  Yes  No If so, whom? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Who is your OB/GYN? \_\_\_\_\_

### Venous Health History

1. Have you ever had vein stripping surgery?  Yes  No  
If yes, when and which leg? \_\_\_\_\_

2. Have you ever had sclerotherapy?  Yes  No  
If yes, which leg and where on the leg? \_\_\_\_\_

3. Have you ever had a blood clot?  Yes  No  
If yes, which leg and when? \_\_\_\_\_

4. Have you ever had phlebitis?  Yes  No  
If yes, which leg and when? \_\_\_\_\_

5. Do you experience any of the following in your legs?

Aching/Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Ankles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heaviness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Throbbing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tiredness/Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg Cramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itching/Burning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	_____

6. Have your veins gotten worse in the recent months?  Yes  No  
Describe: \_\_\_\_\_

7. Do you wear prescription compression hose?  Yes  No

8. Do you ever elevate your legs to relieve discomfort?  Yes  No

**(Please flip over and fill out back of page.)**

9. Do you take any medication for pain in your legs?  Yes  No  
If yes, what do you take and how often? \_\_\_\_\_

10. What type of work do you do? \_\_\_\_\_

### **Family History**

1. Does anyone in your family have varicose veins or spider veins? Yes No  
If so, whom? \_\_\_\_\_

### **Medical History:**

1. Please list any medical conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please list any surgical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What medications are you allergic to? \_\_\_\_\_

4. Please list your current medications? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you currently Pregnant?  Yes  No Breastfeeding?  Yes  No

6. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_