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	☐ Yes ☐ No	☐ Right ☐ Left
Pigmentation (discoloration)	☐ Yes ☐ No	☐ Right ☐ Left
Dermatitis (eczema)	☐ Yes ☐ No	☐ Right ☐ Left
Aches or Pain in the legs	☐ Yes ☐ No	☐ Right ☐ Left
Heaviness or tired legs	☐ Yes ☐ No	☐ Right ☐ Left
Itching in legs	☐ Yes ☐ No	☐ Right ☐ Left
Night Cramps	☐ Yes ☐ No	☐ Right ☐ Left
Blood clots (requiring blood thinners)	☐ Yes ☐ No	☐ Right ☐ Left
Superficial Phlebitis (clots in surface veins)	☐ Yes ☐ No	☐ Right ☐ Left
Pulmonary Emboli (blood clots in lungs)	☐ Yes ☐ No	
Swelling in the legs or ankles	☐ Yes ☐ No	☐ Right ☐ Left
Ulcerations on the leg	☐ Yes ☐ No	☐ Right ☐ Left
Recent or Remote Leg Trauma	☐ Yes ☐ No	☐ Right ☐ 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_____