

## 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 \_\_\_\_\_