



## PATIENT VENOUS HISTORY

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 1. Have you had any prior treatment for varicose/spider veins?<br>Date(s) of treatment _____<br>Type of agent(s) used, if known _____ | YES | NO |
| 2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis?   | YES | NO |
| 3. Do you have a family history of varicose/spider veins?<br>If so, relationship(s) to you _____                                      | YES | NO |
| 4. Are you currently, or have you been on any hormone therapy of birth control pills?<br>If so, please list _____                     | YES | NO |
| 5. Have you had any pregnancies? If so, how many? _____<br>If so, did your varicose/spider veins increase after your pregnancies?     | YES | NO |
| 6. Do you wear support hose? If yes, are they prescription or over-the-counter?   | YES | NO |
| 7. Are you presently employed? If so, type of job _____   | YES | NO |
| 8. Do you sit or stand for long periods of time? How many hours per day? _____  | YES | NO |
| 9. Do you take any pain medications for your varicose/spider veins (Aspirin/Tylenol)?   | YES | NO |
| 10. Do you elevate your legs to relieve your symptoms? If so, does it work?   | YES | NO |

Additional History \_\_\_\_\_  
\_\_\_\_\_

## COMPREHENSIVE HISTORY CHECKLIST (Please check all those that apply)

|                           | Right Leg | Left Leg |
|---------------------------|-----------|----------|
| <b>Edema</b>              |           |          |
| <b>Pain</b>               |           |          |
| <b>Tiredness</b>          |           |          |
| <b>Ulceration</b>         |           |          |
| <b>Skin Color Changes</b> |           |          |
| <b>Spider Veins</b>       |           |          |
| <b>Varicose Veins</b>     |           |          |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_