VEIN TREATMENT MEDICAL HISTORY

PATIENT NAME: _____ **TODAY'S DATE:** _____

Please circle if you have had any of the following:

High Blood Pressure	Heart Disease	HIV	Hepatits	Stroke
Mitral Valve Prolapse	Bleeding Disorder	Pulmonary Embolus	Seizures	Diabetes
Deep Vein Thrombosis	Open Heart Surgery		Superficial Phlebitis	

Are you pregnant or nursing? YES NO ***Allergies:*** _____

Surgical History (please indicate all surgeries and approximate year) _____

_____

_____

List <u>all</u> medications you are currently taking: _____

Herbals/Supplements you are currently taking: _____

DO YOU HAVE ..... (please check):

___aching or throbbing	___leg pain	___tenderness	___burning pain in leg
___night cramps	___tired or heavy legs	___ankle swelling	___night cramps
___red/warm areas	___varicose veins (bulging)	___hard lumps	___skin changes
___ulcers or ulceration	___itching	___spider veins	___other:

PERSONAL HISTORY OF VARICOSE VEINS or SPIDER VEINS:

Number of years you have had trouble with your veins ____

Related to pregnancy	YES	NO
Related to accident/trauma	YES	NO
Are you developing new veins	YES	NO
Are your present veins getting worse	YES	NO
Does your discomfort/leg pain interfere with your activities of daily living?	YES	NO
Do you smoke	YES	NO

Other _____

<u>Are your symptoms worse with</u>:

Prolonged standing	YES	NO
Prolonged sitting	YES	NO
Menstrual cycle	YES	NO

<u>Are your symptoms relieved with:</u>

Rest/Elevation of legs	YES	NO

FAMILY HISTORY OF VARICOSE VEINS or SPIDER VEINS *(please check)*

___mother ___father ___sister ___brother ___grandmother ___grandfather

PREVIOUS CONSERVATIVE TREATMENT YOU HAVE TRIED:

Have you ever worn compression stockings for your veins? When? _____

Did they help your symptoms (leg pain/swelling)? Totally? Partially? _____

Do you take pain medications (Advil, Tylenol, aspirin) for your leg pain/veins? _____

PREVIOUS TREATMENT HISTORY:

Ligation/Stripping Surgery If so, which leg? _____ When? _____

Injection treatments If so, which leg? _____ When? _____ Solution Used _____

Laser Therapy If so, When? _____

Other: _____

Patient Signature: _____ Date: _____