

# New Patient Venous History

Name \_\_\_\_\_ Date \_\_\_\_\_  
FIRST MIDDLE LAST

Primary Physician \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason you are seeking treatment for your veins: \_\_\_\_\_

Have you ever had treatment for your veins?  Yes  No

If yes, where and what type of treatment? \_\_\_\_\_

How long have you had the veins you are concerned about? \_\_\_\_\_

Are your veins getting worse? \_\_\_\_\_

Do you or have you ever worn compression hose?  Yes  No If so, how long? \_\_\_\_\_ months

If you have worn compression hose, were they over-the-counter or prescription? \_\_\_\_\_

Do you take any medications for your veins? (including over-the-counter medicines such as Tylenol or Ibuprofen)

Does prolonged sitting aggravate your veins? \_\_\_\_\_ Prolonged standing? \_\_\_\_\_

Does elevating your legs improve your symptoms? \_\_\_\_\_

Have you had any pregnancies? If so, how many? \_\_\_\_\_

Did you varicose/spider veins develop after your pregnancies? \_\_\_\_\_

Are you currently, or have you ever been on any hormone therapy or birth control pills?  Yes  No

## Symptom Checklist (Please check all that apply):

- |   |  |
|---|--|
| Spider Veins  | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Varicose Veins  | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Pain  | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Edema (swelling)  | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Tiredness   | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Itchiness   | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Restless legs   | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Heaviness   | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Skin Color Changes (not counting the veins you can see) | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Bleeding episodes from varicosities                     | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |
| Inflammation (thrombophlebitis) of varicosities         | <input type="checkbox"/> Right leg <input type="checkbox"/> Left leg |

Please list any allergies you have: \_\_\_\_\_

Please list your medications: \_\_\_\_\_

## Patient Medical History

Do you have:

History of leg vein clots (Deep Venous Thrombosis, DVT)?  Yes  No

History of blood clots in the lung (Pulmonary Embolism, PE)?  Yes  No

Personal or family history of abnormal blood clotting (Hypercoagulability)?  Yes  No

History of multiple miscarriages?  Yes  No

Please explain any "yes" answers from above: \_\_\_\_\_

# New Patient Venous History (continued)

Please circle any of the following medical conditions that you might have:

High Blood Pressure

Cancer

Heart Disease

Lung Disease

Diabetes

Liver Disease

Kidney Disease

Asthma

Please list any pertinent medical condition you may have that we have not listed: \_\_\_\_\_

Please list previous surgeries and dates: \_\_\_\_\_

## Social History

Are you presently employed? If so, type of job? \_\_\_\_\_

Do you sit for long periods of time? How many hours per day? \_\_\_\_\_

Do you stand for long periods of time? How many hours per day? \_\_\_\_\_

Do you consume alcohol? How much per week? \_\_\_\_\_

Do you smoke? How long? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_

Are you (circle one)? single | married | divorced | widowed

## Family Medical History

Family history of leg vein or lung blood clots (DVT or PE)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Family history of varicose veins or spider veins? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, were any procedures performed? \_\_\_\_\_

## Review of Systems

Neuro

Headaches \_\_\_\_\_ Yes \_\_\_\_\_ No

Changes in Vision \_\_\_\_\_ Yes \_\_\_\_\_ No

Balance Difficulties \_\_\_\_\_ Yes \_\_\_\_\_ No

Fainting \_\_\_\_\_ Yes \_\_\_\_\_ No

Dizzy \_\_\_\_\_ Yes \_\_\_\_\_ No

Cardiovascular

Chest Pain \_\_\_\_\_ Yes \_\_\_\_\_ No

Irregular Heartbeat \_\_\_\_\_ Yes \_\_\_\_\_ No

Heart Murmur \_\_\_\_\_ Yes \_\_\_\_\_ No

Low Exercise Tolerance \_\_\_\_\_ Yes \_\_\_\_\_ No

Pulmonary

Shortness of Breath \_\_\_\_\_ Yes \_\_\_\_\_ No

Chronic Cough \_\_\_\_\_ Yes \_\_\_\_\_ No

Gastrointestinal

Nausea or Vomiting \_\_\_\_\_ Yes \_\_\_\_\_ No

Diarrhea \_\_\_\_\_ Yes \_\_\_\_\_ No

Cramping \_\_\_\_\_ Yes \_\_\_\_\_ No

Constipation \_\_\_\_\_ Yes \_\_\_\_\_ No

Genitourinary

Dysuria (pain with urination) \_\_\_\_\_ Yes \_\_\_\_\_ No

Hematuria (blood in urine) \_\_\_\_\_ Yes \_\_\_\_\_ No

Heavy/ Irregular Menstruations \_\_\_\_\_ Yes \_\_\_\_\_ No

Skin

Other rashes or changes not discussed above \_\_\_\_\_

Is there anything we have not asked, that you think we should know? \_\_\_\_\_