HEALTH HISTORY FORM – Ve

Name:	Date: ___ / ___ / ___	Date of Birth: __ / __ / ____
Primary care name:	Weight: _____ lbs	Height: ____ ft ____ in

Symptoms	**R**ight Leg	Left Leg	
Aching/pain in legs			Please list any major surgeries or hospitalizations:_____
Heaviness			
Tiredness/fatigue			
Itching/burning/warmth			
Leg cramping			
Leg restlessness			
Throbbing			Prior ultrasound/CT scan/ Angiogram When :_____ Where:_____
Swelling			
Leg restlessness			

Do symptoms interfere with your sleep?	Yes	No
Are your symptoms worse later in the day?	Yes	No
Are your symptoms worse with or after activity?	Yes	No
Do your symptoms keep you from doing anything?	Yes	No
Do you find the need to move your leg(s) to relieve an uncomfortable feeling?	Yes	No

Conservative Measures Used *Currently* or *Previously* (check all that you have tried)		
Pain medication	Weight loss	Compression stockings/wraps: _____
Exercise	Leg elevation	How long: _____months _____years

HEALTH HISTORY FORM – Ve

Please check below if you have, or have had, any of the following:

- ❑ A prior evaluation for your veins: _____ (yr)
- ❑ Previous vein surgery or laser treatments: _____ (yr) ___ R ___ L
- ❑ Previous vein injections: _____ (yr) ___ R ___ L
- ❑ Bleeding from a vein: _____ (yr) ___ R ___ L
- ❑ A leg ulceration: _____ (yr) ___ R ___ L
- ❑ Superficial thrombophlebitis or an inflammation of a vein:_____ (yr)___ R ___ L
- ❑ Any type of blood clot: _____ (yr) ___ R ___ L
- ❑ Any type of clotting disorder: _____ (Diagnosis)
- ❑ Family history of blood clots, if yes, relation: _____
- ❑ Diagnosed with a PFO (patent foramen ovale)
- ❑ Personal history of aneurysm. If yes, when_____
- ❑ Family history of aneurysm. If yes, relation _____

Women Only (Please check all that apply):

- ❑ Are you pregnant or considering pregnancy in the future?
- ❑ Are you breastfeeding?
- ❑ Are your legs more painful associated with menstruation?
- ❑ Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy?

Number of pregnancies: _____	Deliveries: _____
Miscarriages: _____	Children's ages: _____

Medication history

Have you taken following meds	Now taking	List of medications currently taking:
Apixaban/Eliquis		
Coumadin/Warfarin		
Cilostazol/Pletal		
Clopidogrel/Plavix/Aspirin		
Cholesterol lowering meds		
Insulin/Lantus/humolog etc		
Metformin/Glipizinde		