Venous History Form

Name: _____ **Age:**_____ **Date:**_____

Have you ever had vein stripping? If yes, when and which leg:

_____

_____

Have you ever had vein injections? If yes, when and which leg:

_____

_____

Have you ever had a blood clot? If yes, when and which leg:

_____

Have you ever had phlebitis? If yes, when and which leg:

_____

Does anyone in your family have or have had varicose or spider veins, leg ulcers or swelling:

_____

Do you experience any of the following: (Please circle)

Aching Heaviness Tired Itching Pain
Leg Cramps Restless Legs Throbbing Other: _____

Please circle YES or NO to the following questions

Have your veins gotten worse in recent months? YES NO

Do you take medication for pain? YES NO
If yes, what medication: _____

Do you elevate your legs to relieve discomfort? YES NO

Do you wear support hose prescribed by a doctor? YES NO
If yes, what type and for how long have you worn the support hose? _____

Do you wear nonprescription light support hose? YES NO
If you circled yes, do they provide relief? YES NO

Do you have problems walking? YES NO
If yes, how does it affect you: _____

Do you stand a lot during the day? YES NO

Have you ever had any tests done on your veins? YES NO
If yes, what type and where on your legs: _____

Have you been diagnosed with saphenous vein reflux? YES NO