VEIN HISTORY

Patient Name_____ Date:_____

The purpose for today's consultation: ☐ **Cosmetic** ☐ **Medical** ☐ **Both**

Indicate which in the following problems you have experienced?

	Right leg	Left leg	Prior Treatment	How many years
Pain				
Thigh				
Calf				
Foot				
Swelling of legs				
Skin rash/ulcer				

If pain: please circle the type of pain you're experiencing:
Pain-cramps after activity / resting pain-cramps / night cramps / leg fatigue / numbness / burning / other:_____

If previous treatments for any of the above please indicate date and prior procedure performed: Did it help? yes / no

_____

If you experienced any of the above symptoms in your lower limbs please indicate how you are affected by:

	Better	Worse	No Change	If this item makes better/worse
Extended periods standing				How long?
Warm weather or heat				
Menstrual periods				
Exercising/walking				Approx how far?
Medication				Name of medication?
Leg elevation or at rest				
Elastic stockings				Length of time worn?

Personal/ family history

History of:	Personal	Family
Varicose veins		
Injury to legs		
Blood clots		
High blood pressure		
Diabetes (sugar)		
Vascular disease / poor circulation		

Medication history (check any medication that you have taken in the last 6 months)

☐aspirin ☐blood thinners ☐birth control pills ☐chemotherapy ☐thyroid medication ☐cortisone ☐insulin ☐ant-abuse

<u>An unchecked box indicates that you do not; nor have ever had a disease or condition related to the above</u>

Do you feel these problems with your veins are limiting your activities? yes / no
Does your work require prolonged standing? If yes, what percentage of your day is spent standing _____%
Does your work require prolonged sitting? If yes, what percentage of your day is spent sitting _____%
Comments:

Patient Signature_____ Staff Signature_____ 4.03

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