



Medical and Venous History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Primary Physician \_\_\_\_\_

How were you referred to our office?

- Primary Physician, OB/GYN, Other Physician, Newspaper, Magazine, Mailbox Mailer, Other

Reason for Today's Visit:

- Spider Veins, Varicose Veins, Medical, Cosmetic

Please check symptoms that you have or have had in the past:

- Ache, Burning, Heaviness, Throbbing, Itching/Tingling, Swelling/Edema, Pain, Inflammation, Phlebitis, Dermatitis (rash), Ulceration, bleeding, Unsightly Appearance, Tired, Restless Legs, Night Cramps, DVT

Do these symptoms impair your mobility and/or cause inability to perform daily activities?

- YES, NO

Do you work on your feet? YES NO What is your Profession: \_\_\_\_\_

How long have your veins been a concern to you? Months \_\_\_\_\_ Years \_\_\_\_\_

Did your veins develop during pregnancy? YES NO N/A

What have you tried in order to make your legs feel better?

- Compression Hose, Elevate Legs, Soak Legs, Pain Relievers, Nothing

Have you been previously treated by:

- Ligation Surgery, Vein Stripping, Sclerotherapy (Injections), Laser Therapy

Family History: Varicose Veins, Spider Vein, Leg Ulcers

Please check any health issues that you have or have had:

- High Blood Pressure, Heart Disease, Heart Attack, Diabetes, High Cholesterol, Heart Murmur, Asthma/Emphysema, Bleeding Disorder, Superficial Blood Clots, Stroke, Hepatitis, HIV, Deep Blood Clots, Migraine Headaches, Cancer, Other

Please list any surgeries that you have had:

Please list medications including vitamins/herbal supplements:

Please list allergies:

Do you currently smoke? YES NO If yes, How Much per day \_\_\_\_\_ Age you started \_\_\_\_\_
How often do you consume alcohol? Never Occasionally Frequently

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_