

OC Vein Care

VENOUS HEALTH HISTORY FORM

Confidential patient information

Patient Name: _____ **Date:** _____

Date of Birth: _____

Reason for visit: _____

Referring Physician/Primary Care Provider: _____

1. Have you ever been treated for your veins before? Yes No

If yes, please list what kind of treatment :

Sclerotherapy	Yes	No
Vein stripping	Yes	No
Laser therapy (EVLV)	Yes	No
Ultrasound guided injections	Yes	No
Radiofrequency ablation/Closure	Yes	No
Phlebectomy (surgical removal of veins)	Yes	No

Who was your treating physician? _____

When were you treated? _____

How would you describe your results from treatment? _____

2. Have you ever had a blood clot? Yes No
If yes, which leg and when? _____

3. Have you ever had phlebitis? Yes No
If yes, which leg and when? _____

4. Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	Yes	No
Mother	Yes	No
Brother(s)	Yes	No
Sister	Yes	No
Other: _____		

5. Do you experience any of the following in your legs?

Aching/pain?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Heaviness?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Tiredness/fatigue?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Itching/burning?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Swollen ankles?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Leg cramps?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Restless legs?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs
Throbbing?	Yes	During activity or prolong standing	Yes	No	LT / RT leg	Both legs



6. Have your veins gotten worse in recent months? Yes No
 Describe: _____

7. Do you take any medication for pain (i.e., Advil, Motrin) Yes No
 If yes, what medication(s) do you take and how many times/mgs per day? _____

8. How do you relieve your legs discomfort? Yes No
 Leg elevation Yes No
 If yes, how long per day do you elevate and does it provide relief?

Exercise	Yes	No
Aspirin	Yes	No
Walking	Yes	No
Cold compress	Yes	No
Warm compress	Yes	No
Tylenol	Yes	No
Ibuprofen	Yes	No
Support stockings	Yes	No
Flex/extend legs	Yes	No

9. Do you exercise? Yes No

If yes, what kind of exercise and how often?

Does walking or exercising relieve or worsen your leg discomfort? _____

Most insurance companies require the use of graded compression stockings to be worn for a minimum of 6 weeks to 3 months before qualifying for varicose vein treatment.

10. Have you ever worn prescription compression stockings? Yes No
If yes, what type and gradient? How long have you worn them?

11. Do you wear light support hose (i.e., Sheer Energy)?
If yes, do they provide relief? Yes No
12. Do you have any problem walking? Yes No
If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or during/ after exercise)

13. What type of work do you do?

How long do you stand (hours per day) at work? _____
At home? _____
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours)

14. Have you ever had an ultrasound on your veins? Yes No
If yes, when and which leg?

15. Were you diagnosed with saphenous vein reflux? Yes No
16. Name of referring Physician and how long have you been under his care for treatment of this condition?

17. Do you have any allergies to drugs or sensitivities to tape?
If yes, list drugs or type of tape and reaction:

18. Do you have any current medical conditions you are being treated for?
If yes, please list conditions: _____

19. List all medications you are taking (prescription, non-prescription, herbal medicines etc.) and dose

SOCIAL HISTORY:

20. Do you smoke or consume alcohol?

If yes, how much: _____

Marital Status: married/single/ divorced/widowed

PATIENT MEDICAL HISTORY:

Do you have a history of:

Diabetes	Yes	No
Peripheral Vascular disease	Yes	No
Stroke	Yes	No
High blood pressure	Yes	No
Thyroid disease	Yes	No
HIV/AIDS	Yes	No
TIA (transient ischemic attack)	Yes	No
Anemia	Yes	No
Carotid disease	Yes	No
Coronary heart disease	Yes	No
Liver disease	Yes	No
Pulmonary embolus	Yes	No
Bleeding disorder	Yes	No
Easy bruising	Yes	No
Hepatitis	Yes	No
Kidney disease	Yes	No
Heart valve disease	Yes	No
Leg trauma	Yes	No
Blood transfusion	Yes	No
Cancer	Yes	No
Type: _____		
Other: _____		

PAST SURGICAL HISTORY:

Include procedure and year: _____

BLEEDING HISTORY

Aspirin use	Yes	No
Coumadin use	Yes	No

Excessive bleeding	Yes	No
Easy bruising	Yes	No

Review of systems: (circle appropriate symptom)

Constitutional symptoms: Weight loss/gain/night sweats/fever

Skin: Change in skin color/mole/rash

Eyes: Glasses/contacts/change in vision/blurred vision/double vision

Ear, nose, throat and mouth: Ringing in ears/deafness/pain/sinus discharge/bleeding/hoarseness/discharge

Cardiac: chest pain/shortness of breath/palpitations/fatigue/leg swelling

Respiratory: Sputum production/coughing of blood/pain/cough

Gastrointestinal: Nausea/vomiting/vomiting of blood/indigestion/reflux/painful swallowing/diarrhea/constipation/yellow discoloration of skin/tarry stools/bloody stools/change in bowel habits

Genitourinary: Kidney/bladder disease/painful urination/decreased stream/bloody urine

Musculoskeletal: bone/joint deformity/limited motion/pain/weakness/trauma

Neurological: weakness/seizure/faints/paralysis/migraine/unsteady gait/headache/numbness in extremities

Psychological: hallucinations/anxiety/depression/bipolar

Endocrine: thyroid disease/sweating/tremor/change in appetite/constipation

Hematological: Bleeding disorders/thrombophilia/lymph node enlargement

Immunological: immune disorders/immunosuppression

FEMALES:

Are you currently breastfeeding? _____

Are you or could you be pregnant? _____

Last menstrual period: _____

Hormone therapy: _____

Menopause: _____

Last mammogram: _____

Nipple discharge: _____

Lumps: _____

Cyclical pain: _____

Last pelvic examination: _____

Patient Signature: _____

Date: _____