Vein Health History

Please Check All That Apply:

	Right	Left
Heaviness/Fatigue		
Pain/Aching		
Severity of Pain	___ Mild (1-3) ___ Moderate(4-6) ___ Severe(7-10)	
Quality of Pain	___ Achy ___ Crampy ___ Dull ___Sharp ___ Throbbing	
Spider Veins		
Varicose Veins		
Swelling/Edema		
Severity of Edema	___ Mild ___ Moderate ___ Severe	
Skin Discoloration		
Restless Legs		
Itching		
Burning		
How long have you had symptoms?		
Is one leg worse than the other?	____ R ____ L ____ Same	

Leg Ulcers*: (Check All That Apply)*	**Right**	**Left**	How long have ulcer(s) been open?	
Active:				
Healed:			How long did it take to heal?	
Bleeding from veins:				
How long since last episode?			Require Transfusion?	
Vein History: *(Check all that apply)*	**Right**	**Left**		
Phlebitis			How long ago?	# of episodes:
Deep Vein Thrombosis			How long ago?	# of episodes:
Pulmonary Embolus				
Trauma to Legs				
Prominent labial/vulvar veins				
Prominent abdominal veins				
Pelvic pain w/ prolonged sitting				
Pelvic pain w/ intercourse				
Have you had a work-up for clotting problems? ____ Yes ____ No				
Diagnosis of Lymphedema? ____ Yes ____ No				

Symptoms are worsened by:

___ Prolonged standing	___ Premenstrual
___ Prolonged sitting	___ Pregnancy
___ Walking/Exercise	___ After Exercise
___ Heat	

Symptoms interfere with my daily living:

___ Work	___ Long car ride
___ Leisure Activity	___ Childcare
___ Routine Activity	___Sleep
___ Air Travel	

Conservative measures attempted to control symptoms:

___ Leg Elevation	___ Therapeutic Compression Stockings
___ Exercise -Times per week _____	___ Warm Soaks
___ Weight Loss	___ Cold Soaks
___ Avoidance of prolonged sitting/standing	___ Pain Medications:

****Compression Stocking Use:**

First Used:	Use Currently?:
# of years used:	Compression Strength: ___ 15-20 mm ___ 20-30 mm ___ 30-40 mm
# of months used:	
Months used continuously in past year:	

*****At least 3 months recent continuous stocking use is required for ablation preauthorization for most insurances*****

I have achieved relief of symptoms with:

___ Leg Elevation	___ Exercise	___ Weight Loss	___ Avoidance of prolonged sitting or standing
___ Therapeutic compression stockings	___ Warm Soaks	___ Cold Soaks	___ Pain Medication

Prior Vein Treatments: If so, when? _____ By whom? _____

___ Injection Sclerotherapy	___ Radiofrequency Closure
___ Ultrasound Guided Sclerotherapy	___ Laser Ablation
___ Vein Stripping	___ Phlebectomy
___ High Ligation	___ Laser/Radio frequency surface treatment of spider veins

Medical History:	**Years**		**Years**		**Years**
___ Aortic Aneurysm		___ Gout		___ Migraine Headaches w/ Aura	
___ Anemia		___ Heart Disease		___ Mitral Valve Prolapse	
___ Arthritis		___ Heart Murmur		___ Osteoporosis	
___ Asthma		___ Hepatitis Type ___		___ Pace Maker	
___ Atherosclerosis		___ High Cholesterol		___ PAD/Poor Circulation	
___ Blood disorders		___ HIV		___ Patent Foramen Ovale	
___ Blood Clot		___ Hormone Problems		___ Peptic Ulcer Disease	
___ Bronchitis/Emphysema		___ Hypertension		___ Prosthetic Heart Valve	
___ Cancer of _____		___ Hypothyroidism		___ Pulmonary Embolus	
___ Cirrhosis		___ Irritable Bowel Syndrome		___ Seizures	
___ Crohn's Disease		___ Kidney Disease		___ Stroke/TIA	
___ Depression		___ Liver Disease		___ Superficial Thrombophlebitis	
___ DVT		___ Lumbar Spine Disease		___ Trauma to Leg(s)	
___ Diabetes		___ Lupus		___ Ulcerative Colitis	
___ Diverticulosis		___ Lymphedema		___ Other medical problems:	
___ GERD/Reflux		___ Migraine Headaches			

Female Medical History:

___ Pregnancies	How Many? _____	___ Pregnant now/planning pregnancy soon
___ Vaginal Deliveries	How Many? _____	___ Currently Breastfeeding
___ C-Section	How Many? _____	___ Contraceptives
___ Stillbirth/Miscarriage	How Many? _____	___ Hormone Therapy

Vaccination History:

Have you received the Influenza Vaccine? __ Yes __ No	If so, when?
Have you received the Pneumonia Vaccine? __ Yes __ No	If so, when?

Surgical History:	**Year**		**Year**		**Year**
___ Appendectomy		___ Hernia Repair __R __L		___ Prostate Surgery	
___ Breast Surgery __R __L		___ Hip Replacement __R __L		___ Skin Cancer Surgery	
___ C-Section		___ Hysterectomy		___ Thyroid Surgery	
___ CABG		___ Knee Replacement __R __L		___ Tonsillectomy	
___ Cholecystectomy		___ Lung Resection __R __L		___ Other Surgery:	
___ Hemorrhoidectomy		___ Plastic Surgery			

Family History:

Is there a history in your **family** of spider or varicose veins?		
___ Mother	___ Siblings	___ Grandparents
___ Father	___ Aunt/Uncle	___ Child
Is there a history in your **family** of deep venous thrombosis, stroke or clotting disorders? (Note which)		
___ Mother	___ Siblings	___ Grandparents
___ Father	___ Aunt/Uncle	___ Child

Do any major medical problems run in your family? Include consideration of the following: ***diabetes, heart disease, respiratory problems, high blood pressure, kidney disease, cancer, bleeding problems, breast problems, thyroid problems, thyroid problems, or gastrointestinal problems****. Please list your primary relatives and the status of their health:*

	Age	**Health Problems**	**If deceased, age at death**	**Cause of death**
Father				
Mother				
Siblings				
Brother Sister				
Brother Sister				
Brother Sister				
Children				

Social History:

Marital Status:	___ Single	___ Married	___ Divorced	___ Widowed
Children:	___ Yes ___ No	Number of Children: ___		
Occupation:	_____		___ Full-Time	___ Part-Time
Job w/ Prolonged:	___ Heavy Lifting	___ Repetitive Movement	___ Standing	
	___ Moderate Lifting	___ Sitting	___ Walking	
Alcohol Use:	___ Never	___ Yes	___ Drinks/week	___ # Per Occasion
Street/Recreational Drug Use:	___ Never	___ Within last 90 days		
Smoking/Tobacco Use:	___ Never	___ Quit ___ # of years ago	___ Yes ___ Packs/day	___ Total Years Smoked
___ Age Started	___ Have you ever thought of quitting? ___Y ___N		__Are you ready to quit? ___Y ___N	

Medication Allergies: ____ None ____ Yes

If yes, to what and what was your reaction?

_____

_____

Prior reaction to Lidocain, Iodine or Latex? ____ None ____ Yes If yes, reaction? _____

Medications with dosage and schedule (or frequency) ___ None

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Review of Systems *(Please check all that apply):*

Constitutional Symptoms:	**Respiratory:**	**Cardiovascular:**	**Integument:**
__ Problems w/ general health	__ Chronic/Freq. cough	__ Chest Pain	__ Rashes
__ Recent weight loss	__ Cough/spit up blood	__ SOB with walking	__ Skin lesions
__ Recent weight gain	__ Wheezing	__ SOB while lying down	__ Ulcers
__ Fever		__ Swelling in legs/ankles	__ Itching
__ Fatigue	**Gastrointestinal**	__ Palpitations	__ Heavy sweating
__ Night Sweats	__ Difficulty/pain swallowing		__ Hair loss
	__ Heartburn	**GU- Male:**	__ Easy skin bruising
Eyes	__ Nausea	__ Infection of penis	__ Eczema
__ Decreased vision	__ Vomiting of blood	__ Impotence	
__ Loss of vision	__ Duo/gastric ulcer	__ Enlarged prostate	**Neurological**
__ Discharge	__ Indigestion	__ Penile discharge	__ Convulsions
__ Double vision	__ Jaundice	__ Infected prostate	__ Dizziness
__ Eye Pain	__ Hemorrhoids	__ Infection of testicle	__ Fainting spells
__ Floaters	__ Rectal bleeding		__ Loss of consciousness
__ Red Eyes	__ Pain on defecation	**GU- Female:**	__ Frequent headaches
__ Tears	__ Black tarry stools	__Irregular periods	__ Migraines
	__ Constipation	__Vaginal discharge	__ Disturbances of vision
E**NT/Mouth**	__ Diarrhea	__ Nipple discharge	__ Disturbances of smell
__ Sore throat	__Changes in bowel habits	__ Hernia	__ Disturbances of taste
__ Hoarse voice	__ Abdominal pain		__ Difficulty speaking
__ Hearing loss		**Musculoskeletal**	__ Involuntary movement
__ Tinnitus (ringing in ears)	**Endocrine:**	__ Hip Pain	__ Tremors
__ Sinus problems	__ Heat intolerance	__ Knee Pain	__ Abnormal numbness
	__ Cold intolerance	__ Ankle Pain	__ Drooping of face
	__ Altered menses	__Shoulder Pain	__ Nervousness
	__ Fatigue	__ Wrist Pain	__ Mental Illness
Psychiatric:	__ Excessive thirst	__ Back Pain	
__ Anxiety	__ Excessive urination	__ Muscle spasms	**Allergy/Immunology:**
__ Depression	__ Steroid use	__ Decreased range of motion	__ Rashes
__ Mood swings	__ Blood in urine		__ Itching
__ Insomnia	__ Pain/burning w/ urination	**Blood/Lymphatic System:**	__ Hives
__ Hyperactivity	__ Frequent/reoccurring bladder infections	__ Enlarged Lymph nodes	__ Recurrent infections
__ Night sweats	__ Kidney infections	__ Fever	__ Other:
	__Difficulty passing urine	__Bruising	
	__ Urinating more than 1 time per night	__Bleeding Tendencies	
	__ Incontinence	__Chronic Sores	

Do you have an Advanced Directive? ___Yes ___No If yes, do you have a designated medical decision maker? ___Yes ___ No