



### Venous Health History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Directions: Please answer the following questions. Provide estimates for date of occurrence.

#### Past Medical History

1. Have you ever had vein stripping surgery  Yes  No  
If yes, when and which leg? \_\_\_\_\_
2. Have you ever had vein injections?  Yes  No  
If yes, which leg and where on the leg? \_\_\_\_\_
3. Have you ever had a blood clot?  Yes  No  
If yes, which leg and when? \_\_\_\_\_
4. Have you ever had phlebitis?  Yes  No  
If yes, which leg and when? \_\_\_\_\_

#### Family History

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

- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Father     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |                    |                                |                               |                               |                             |
|--------------------|--------------------------------|-------------------------------|-------------------------------|-----------------------------|
| Aching/pain?       | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Heaviness?         | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Tiredness/fatigue? | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Itching/burning?   | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Swollen ankles?    | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Leg cramps?        | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Restless legs?     | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Throbbing?         | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Both | <input type="checkbox"/> No |
| Other?             | _____                          |                               |                               |                             |

2. Have your veins gotten worse in recent months?  Yes  No

3. Do you take any medication for pain (i.e., Advil, Motrin)  Yes  No

If yes, what medication do you take and how many times/mgs per day? \_\_\_\_\_

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4. Do you elevate your legs to relieve discomfort? Yes No

If yes, how long per day do you elevate and does it provide relief?

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5. Do you exercise? Yes No

If yes, what kind of exercise and how often? \_\_\_\_\_

6. Do you wear prescription compression stockings?  Yes No

If yes, what type and gradient? How long have you worn them? \_\_\_\_\_

7. Do you wear light support hose (i.e., Sheer Energy)? Yes No

If yes, do they provide relief? Yes No

8. Do you have any problem walking?  Yes No

If yes, how does it affect you? \_\_\_\_\_

9. What type of work do you do? \_\_\_\_\_

How long do you stand (hours per day) at work? \_\_\_\_\_ At home? \_\_\_\_\_

10. Have you ever had any test(s) done on your veins? Yes No

If yes, when and what type of test and where on the leg? \_\_\_\_\_

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11. Were you diagnosed with saphenous vein reflux? Yes No

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