

VEIN HISTORY FORM

Please complete left side of form only.

Date: _____

Name: _____

DOB: _____ Sex: M F Insurance Provider: _____

How did you hear about us? _____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems Y N Leg: R L
 Phlebitis (vein redness/tenderness) Y N Leg: R L
 Blood clots Y N Leg: R L
 Deep vein thrombosis (DVT) Y N Leg: R L
 Saphenous vein reflux Y N Leg: R L

Do you experience any of the following in your leg(s):

Aching/pain Y N Leg: R L
 Heaviness Y N Leg: R L
 Tiredness/fatigue Y N Leg: R L
 Itching/burning Y N Leg: R L
 Swelling Y N Leg: R L
 Cramps Y N Leg: R L
 Restless legs Y N Leg: R L
 Throbbing Y N Leg: R L
 Skin or ulcer problems Y N Leg: R L
 Other: Y N Leg: R L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain Y N What? _____
 Elevation of legs Y N What? _____
 Wear support hose Y N What? _____

II. Family History

Have any of your family members had:

Varicose veins Y N Who? _____
 Vein stripping Y N Who? _____
 Blood coagulation disorder Y N Who? _____
 Blood clots Y N Who? _____
 Stroke, heart attacks or pulmonary emboli Y N Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

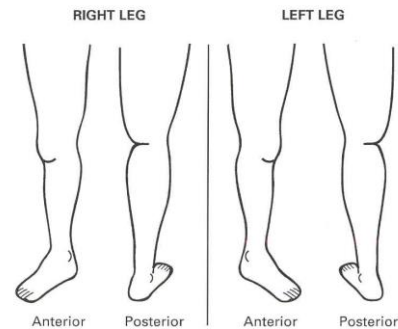
Sclerotherapy Y N Leg: R L
 Laser therapy (spider veins) Y N Leg: R L
 Phlebectomy Y N Leg: R L
 Vein stripping surgery Y N Leg: R L
 RF ablation (VNUS Closure®) Y N Leg: R L

IV. Personal Activities List

Does your work require:

Prolonged standing periods Y N
 Prolonged sitting periods Y N
 Do you exercise regularly? Y N
 Do you smoke? Y N
 Pregnancies Y N How many? _____

V. Vein Screening (to be completed by screening provider)



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

No signs of venous disease Spider veins
 Visible varicose veins Edema
 Pigmentation Healed ulcers Active ulcers

LEFT LEG (check all that apply)

No signs of venous disease Spider veins
 Visible varicose veins Edema
 Pigmentation Healed ulcers Active ulcers

Clinical Assessment:

Chronic venous insufficiency R L
 Other: _____ R L

Treatment Plan:

Duplex ultrasound R L
 Sclerotherapy R L
 Medical compression stockings R L
 Other: _____ R L

Screening Provider Signature: _____

Follow-Up Appointment

Date: _____ Time: _____

Physician: _____

Physician Phone Number: _____

NOTES: