NAME:_____ DATE:_____
DATE OF BIRTH:_____ _ AGE:_____

VENOUS HEALTH HISTORY

Symptoms: ***(Please check if yes)***	**R**	**L**
Aching / pain in legs	□	□
Heaviness	□	□
Tiredness / fatigue	□	□
Itching / burning / warmth	□	□
Leg cramping	□	□
Leg restlessness	□	□
Throbbing	□	□
Swelling	□	□

Do your symptoms interfere with your sleep? □
Are your symptoms worse later in the day? □
Are your symptoms worse with or after activity? □
Do your symptoms keep you from doing anything? □

Check if you've had any of the following:

Heart disease □
Peripheral arterial disease □
HIV □
Hepatitis □
High blood pressure □
Diabetes □
Cancer □
Leg trauma / surgery □
Asthma/COPD □
Major surgery / hospitalizations: □
_____
_____
_____

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

□ Was diagnosed with PAD in past
□ Have/had cramping leg pain that worsens with walking, forcing me to stop walking
□ Feet/toes become pale and painful with exercise or when elevating them
□ Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

□Pain medications □Weight loss □ Leg elevation □ Job change
□ Exercise □ Compression stockings or leg wraps? Strength of stockings: _____ mmHg

***Please list your* weight:** _____ lbs and **height:** ____ft ____in

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Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling? □
Do(es) your leg(s) feel better when moving it (them) or walking? □
Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? □
Are your leg symptoms worse later in the day or night? □

Please check below if you have, or have had, any of the following:

□ A prior evaluation for your veins: _____*(yr)*
□ Previous vein surgery or laser treatments: _____*(yr)*____*R*____*L*
□ Previous vein injections: _____*(yr)*____*R*____*L*
□ Bleeding from a vein: _____*(yr)*____*R*____*L*
□ A leg ulceration: _____*(yr)*____*R*____*L*
□ Superficial thrombophlebitis or an inflammation of a vein: _____*(yr)*____*R*____*L*_____ *(Location)*
□ Any type of blood clot: _____*(yr)*____*R*____*L*_____ *(Location)*
□ Any type of clotting disorder: _____ *(Diagnosis)*
□ Migraines with aura
□ Diagnosed with a PFO (patent foramen ovale)

□ A family history of vein disease
□ A family history of leg ulceration
□ A family history of blood clots
□ A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? □
Are you breast-feeding? □ Are your legs more painful associated with menstruation? □
Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? □
Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Children's ages:_____