

Vein Care Specialists
Patient Health History Form

Name: _____ DOB: _____ Date: _____

When did your symptoms start? _____

Do you have any of the following?

- Pain Aching Throbbing Heaviness Leg Tiredness Skin discoloration
 Bleeding Ulcers/sores Itching Leg swelling Leg cramps Burning
 Superficial vein clots Restless Leg Syndrome

Do your symptoms involve one or both legs?

- Right Left Both

Please rate your pain level: (circle one) 0 (none) 1(very low)-2-3-4-5-6-7-8-9-10(very high)

Have you tried over-the-counter pain medication for leg pain/discomfort? No Yes

If yes, type of medication _____

Do you feel your symptoms interfere with or impair any of the following? (Circle that apply)

Work	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>
Housework	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>
Walking	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>
Sitting	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>
Kneeling	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>
Standing	<i>none</i>	<i>a little</i>	<i>some</i>	<i>most of the time</i>	<i>all the time</i>

Do you use compression stockings? No Yes Duration of use _____

Do you take any blood thinners (anticoagulation or antiplatelet medications)? No Yes

Do you have a personal history of DVT or other blood clots or a clotting disorder? No Yes

Do you have a family history of varicose veins or vein disease? No Yes

Have you had prior vein procedures? No Yes

Do you have a history of migraines with aura? No Yes

Do you have a history of patent foramen ovale or other heart shunts? No Yes

(a hole in the heart that didn't close the way it should after birth)