

VASCULAR HEALTH & HISTORY FORM

Name: _____ Date of Birth ____ / ____ / ____ Date: _____

Reason for today's visit? _____

VENOUS ABNORMALITIES

Please indicate whether you have or have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aching/pain in the legs | <input type="checkbox"/> Tiredness/fatigue in the legs | <input type="checkbox"/> Itching/tingling in the legs |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Heaviness in the legs | <input type="checkbox"/> Deep vein thrombosis (DVT) | <input type="checkbox"/> Numbness in the legs |
| <input type="checkbox"/> Tiny red veins | <input type="checkbox"/> Legs | <input type="checkbox"/> Face |
| <input type="checkbox"/> Purple vein networks | <input type="checkbox"/> Legs | <input type="checkbox"/> Face |
| <input type="checkbox"/> Bulging varicose veins | <input type="checkbox"/> Legs | <input type="checkbox"/> Face |
| <input type="checkbox"/> Large veins inner thigh or vulva | <input type="checkbox"/> Other area _____ | |
| <input type="checkbox"/> Leg trauma (<i>please describe</i>) _____ | <input type="checkbox"/> Other area _____ | |
| <input type="checkbox"/> Other vein abnormality (<i>please describe</i>) _____ | <input type="checkbox"/> Other area _____ | |

Please rate the following concerns on a scale of (0) to (10). A zero (0) means no concern, and ten (10) is extreme:

_____ Leg pain - standing _____ Leg pain - sitting _____ Leg pain - lying down _____ Appearance of veins

When did you first experience vein problems? _____

If you have symptoms, what relieves them? _____

Please describe your current symptoms: _____

Have you ever worn compression hose? Yes No If yes, for how long? _____

Have you ever seen another healthcare provider for your vein concerns? Yes No

If yes, who and when? _____

LIFESTYLE

Have you ever smoked? Yes No If yes, when did you start and for how long? _____

How often do you consume alcohol? Never Occasionally Frequently

Are you currently working? Yes No Occupation _____

Are you required to sit or stand for long periods of time at work? Yes No If yes, for how long? _____

VASCULAR HISTORY

Do varicose or spider veins run in your family? Yes No If yes, who? _____

Do blood clotting disorders, deep venous thrombosis, or stroke run in your family? Yes No

If yes, which / who? _____

Have you been treated for vein problems? Yes No

If yes, what treatment(s) have you had? Include date(s) of last treatment(s).

- | | |
|---|--|
| <input type="checkbox"/> Injections _____ | <input type="checkbox"/> Endovenous laser ablation of varicose veins _____ |
| <input type="checkbox"/> Vein stripping _____ | <input type="checkbox"/> Radiofrequency closure of varicose veins _____ |
| <input type="checkbox"/> Local excision _____ | <input type="checkbox"/> Laser / intense pulsed light for spider veins _____ |
| <input type="checkbox"/> Ligation surgery _____ | <input type="checkbox"/> Other _____ |

How much did this relieve symptoms? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How much did this improve appearance? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

MEDICAL HISTORY Do you have a history of:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV infection | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ankle skin changes | <input type="checkbox"/> Leg ulcers | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lupus | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pulmonary embolus | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rupture of a vein |
| <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Other _____ | | |

Do you have a PFO (Patent Foramen Ovale) or ASD (Arterial Septal Defect)? Yes No

Do you have an allergy to lidocaine? Yes No

Have you had an allergic reaction to tape? Yes No

Do you have an allergy to latex products? Yes No

Please list other allergies and sensitivities to medication:

Please list all medications you currently take, including vitamins/herbal supplements:

Please list any medical conditions for which you are being treated:

Please list any surgeries and hospitalizations and when they occurred:

FOR WOMEN ONLY

Do you routinely experience pelvic pain? Yes No If yes, when is it at its worst? _____

Are you pregnant, nursing or planning a pregnancy soon? Yes No If yes, please explain _____

Number of previous pregnancies _____

Do you have varicose veins in the labial or vulvar areas? Yes No

Do you commonly experience pain with intercourse? Yes No