THE VEIN AND VASCULAR TREATMENT CENTERS* ("VVTC")

PATIENT VENOUS HISTORY

Please complete the following - PLEASE PRINT.

Patient Name:________________________ **Birthdate:**__________ **Today's Date:**__________

Occupation:________________________

What are your concerns that bring you here today?______________________________________

Who may we thank for referring you to us?______________________________________

1. Have you ever had any testing done on your veins before? Yes No
   If so, what tests:________________________________
2. Have you ever had prior treatment for varicose/spider veins? Yes No
   Date of treatment:________________________________
   Type of therapy:________________________________
   By whom:________________________________
3. Do you have a family history of varicose/spider veins? Yes No
   If so, relationship(s) to you:________________________________
4. Do you have any problems walking? Yes No
   If yes, please describe:________________________________
5. Do you stand for prolonged periods of time? Yes No
   If so, how long?________________________________
6. Do you sit for prolonged periods of time? Yes No
7. Do you experience: Leg pain? Yes No
   Cramps? Yes No
   Swelling? Yes No
   If so, please describe the pain/cramps/swelling:________________________________
8. What actions do you take to relieve the pain/cramps/swelling?________________________________
   Do you get relief? Yes No
   For how long?________________________________
9. Do you take any medication for your symptoms? Yes No
   If so, what medications?________________________________

* a division of GREAT LAKES RADIOLOGISTS, S.C.

Patient Initials_____

10. Have you ever worn support stockings? Yes No
    If so, did they provide relief? Yes No
    Were these stockings prescribed by a physician? Yes No

11. Have you had any pregnancies? Yes No
    If so, how many?______________________________
    Did your varicose veins increase during your pregnancy? Yes No

10. Do you have a family history of skin ulcerations? Yes No
    Clots in veins? Yes No
    Deep vein thrombosis (DVT)? Yes No

11. Do you have any family history of coronary artery disease? Yes No
    Bypass surgery? Yes No

Current Medical History:

1. Allergies and Reactions:______________________________
____
____
____

2. Current Medications:______________________________
____
____
____

3. List any serious illnesses/injuries/hospitalizations:______________________________
____
____
____

4. Are you currently, or have you been, on any hormone therapy or birth control pills? Yes No

5. Do you smoke? Yes No
   How much in a day?______________________________

6. Do you take blood thinners or aspirins? Yes No

7. Do you have heart disease or high blood pressure? Yes No

8. Are you a diabetic? Yes No

9. Do you have any lung disease? Yes No

10. Have you ever had any blood infections, hepatitis, HIV, AIDS? Yes No

Patient Initials_____

Please mark (X) the symptoms that apply:

	Right Leg	Left Leg
Aching/pain	❑	❑
Edema (swelling)	❑	❑
Tiredness	❑	❑
Ulcerations	❑	❑
Skin color changes	❑	❑
Spider veins	❑	❑
Itching	❑	❑
Burning	❑	❑
Leg cramps	❑	❑
Restless legs	❑	❑
Throbbing	❑	❑

Patient Initials_____