

## Patient Venous History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_ Years \_\_\_\_\_ Months

Please check which symptoms you have:

<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Tired/Heavy Legs	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Itching	<input type="checkbox"/> Aching/Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Stinging
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Open Sore/Ulcer	<input type="checkbox"/> Red Warm Areas	<input type="checkbox"/> Restless Legs
<input type="checkbox"/> None	<input type="checkbox"/> Other: _____		

On a scale from 0(none) to 5 (severe), how would you rate your symptoms? \_\_\_\_\_

Have your symptoms/veins gotten worse in recent months?  No  Yes

Are your symptoms worse with?

- Prolonged sitting/standing
- Hot Baths
- Menstrual Cycle

Are your symptoms improved by?

- Rest and Elevation
- Walking

How do your symptoms alter your daily activities at work/housework? \_\_\_\_\_

How do your symptoms alter your leisure activities such as sports, hobbies, social life, family)? \_\_\_\_\_

Do you stand much at work/home?  No  Yes

How does standing affect your legs? \_\_\_\_\_

Do you need to stop and rest your legs during the day?  No  Yes

Do you need to rest/elevate your legs at the end of your day?  No  Yes

Do you exercise regularly?  No  Yes

Describe activity \_\_\_\_\_

Have you ever worn prescription compression stockings?  No  Yes If yes; For how long? \_\_\_\_\_

Date first worn? \_\_\_\_\_ First prescribed by? \_\_\_\_\_

Pressure:  < 20 mmHg  20-30 mmHg  30-40 mmHg

Type:  Knee-hi  Thigh-hi  Pantyhose

Any improvement of symptoms with stockings?  No  Yes

Have you taken any medications (prescription/ over the counter) for your symptoms?  No  Yes If yes:

Name and strength \_\_\_\_\_ How many times per day? \_\_\_\_\_

Name and strength \_\_\_\_\_ How many times per day? \_\_\_\_\_

Any improvement of symptoms with medications?  No  Yes

Have you ever had treatment for veins?  No  Yes If yes, explain \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_