VEIN centers for excellence™
No one knows legs like we do!

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:

◯ Leg Pain	◯ Tired/Heavy Legs	◯ Tenderness	◯ Ankle Swelling
◯ Itching	◯ Aching/Throbbing	◯ Burning	◯ Stinging
◯ Leg Cramps	◯ Open Sore/Ulcer	◯ Red Warm Areas	◯ Restless Legs
◯ None	◯ 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 _____