Name: _____ **Date:** _____
Referring Physician: _____ **Primary Care Physician:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Allergies:** _____
Past Medical History: _____
Surgical History: _____
Medications: _____
_____

Are your symptoms worse at the end of the day? Yes No
Are the problems you are having in your legs interfering wih your lifestyle? Yes No
Do you have problems walking? Yes No If yes, please explain: _____
_____

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐ Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐ Y ☐N	Leg: ☐R ☐L
Blood clots	☐ Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐ Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐ Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y ☐N	Leg: ☐R ☐L
Heaviness	☐ Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐ Y ☐N	Leg: ☐R ☐L
Itching/burning	☐ Y ☐N	Leg: ☐R ☐L
Swelling	☐ Y ☐N	Leg: ☐R ☐L
Cramps	☐ Y ☐N	Leg: ☐R ☐L
Restless legs	☐ Y ☐N	Leg: ☐R ☐L
Throbbing	☐ Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐ Y ☐N	Leg: ☐R ☐L
Other:	☐ Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐ Y ☐N	What? _____
Elevation of legs	☐ Y ☐N	What? _____
Wear support hose	☐ Y ☐N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐ Y ☐N	Who? _____
Vein stripping	☐ Y ☐N	Who? _____
Blood coagulation disorder	☐ Y ☐N	Who? _____
Blood clots	☐ Y ☐N	Who? _____
Stroke, heart attacks or pulmonary emboli	☐ Y ☐N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

Sclerotherapy	☐ Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐ Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐ Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐ Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐ Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐ Y ☐N	
Prolonged sitting periods	☐ Y ☐N	
Do you exercise regularly?	☐ Y ☐N	
Do you smoke?	☐ Y ☐N	
Pregnancies	☐ Y ☐N	How many? _____

_____