Venous Health History Form

Name: _____ Date: _____ Sex: M or F

Please answer the following questions. Provide your best estimate for dates of occurrence.

1. Have you ever had vein stripping surgery? Yes No
2. Have you ever had vein injections? Yes No

   If yes, when and where on the leg? _____
3. Have you ever had a blood clot? Yes No
4. Have you ever had phlebitis? Yes No
5. Do you experience any of the following? If yes, **please circle**.

   Aching/ pain in your legs Swollen ankles Throbbing Heaviness

   Leg cramps Itching/burning Restless legs Other: _____
6. Do you experience these problems in just one, or both legs? Right Left Both
7. Do you feel that your veins have gotten worse in recent months? Yes No
8. Do you take any medication for pain? Yes No

   If yes, what medication and how often? _____
9. Do you elevate your legs to relieve discomfort? Yes No
10. Do you wear support hose prescribed by a doctor? Yes No

    If yes, what type and how long have you worn them? _____

    Do they provide relief? Yes No
11. Do you spend a significant period of time standing at work or at home? Yes No
12. Have you ever had any test(s) done on your veins? Yes No

    If yes, when? and what type of test? _____
13. Were you diagnosed with saphenous vein reflux? Yes No
14. Has anyone in your family had varicose veins, spider veins, leg ulcers or swollen legs?

If yes, **please circle** which family member.

Father Mother Brother Sister Other: _____