Today's Date:

Patient History Form

Name: _____ **Date of Birth:** _____ **Occupation:** _____

Chief Complaint: Please describe the problems you are experiencing.

Current or past symptoms:

YES	NO		YES	NO	
☐	☐	Leg pain or discomfort	☐	☐	Restless legs
☐	☐	Legs feeling heavy	☐	☐	Enlarged leg veins
☐	☐	Leg cramps	☐	☐	Skin color changes on the leg
☐	☐	Leg burning, itching	☐	☐	Blood clots, DVT, or phlebitis
		Leg swelling			Leg ulcerations

☐ ☐ **Are any of these symptoms worse with prolonged standing or sitting?**

☐ ☐ **Have you had any vein procedures in the past (surgical or cosmetic)?**

Outcome: _____ Previous Imaging Studies: _____

Do you use any of the following to manage your vein/leg symptoms?

YES	NO		
☐	☐	Medication (including over the counter)	List: _____
☐	☐	Leg elevation	How often: _____
		Regular exercise	How often: _____

☐ ☐ Does your job require prolonged sitting or standing?

☐ ☐ Do your symptoms affect any of your daily activities? This can include your job, social life, or even necessary tasks like grocery shopping. If yes, please describe:

Please list your current medications. If you do not take any medications, type "None":

Medication allergies. If you do not have any medication allergies, type "None":

YES	NO	
☐	☐	Smoker? _____ Packs per day? _____ Years? _____
☐	☐	Former Smoker? When did you quit? _____
☐	☐	Drink alcohol? If yes, how many times in the past year have you had 4 or more alcoholic drinks in a day? _____

Male ☐ Female ☐

Height: Weight:

Mother: ☐ Alive ☐ Deceased

Father: ☐ Alive ☐ Deceased

Women only—Date of last menstrual period

YES	NO	
☐	☐	Do you have a history of varicose veins of the vulva?
☐	☐	Do any of your leg/vein symptoms change with your period?
☐	☐	Do you have pain after intercourse?
☐	☐	Do you have pelvic pain?

If yes, do your symptoms get better after lying down? ☐ **YES** ☐ **NO**

Family History: Have any of your family members had:

YES	NO		
☐	☐	Vein stripping or vein surgery?	If yes, who?
☐	☐	Varicose veins?	If yes, who?
☐	☐	Blood coagulation disorder?	If yes, who?
☐	☐	Blood clots?	If yes, who?
☐	☐	Stroke?	If yes, who?
☐	☐	Heart attack?	If yes, who?
☐	☐	Pulmonary embolism?	If yes, who?

List any past surgeries and the approximate year:

Please check if you have any of the following:

- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Peripheral vascular disease
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Wheezing
- ☐ Thyroid disease
- ☐ Gastrointestinal disease
- ☐ History of heart attack
- ☐ Irregular heart beat
- ☐ Congestive heart failure
- ☐ Cancer
- ☐ Mental illness
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Seasonal allergies
- ☐ Liver disease/Hepatitis
- ☐ Chest pain
- ☐ Artificial heart valve
- ☐ Diabetes
- ☐ Epilepsy/Seizure
- ☐ Emphysema
- ☐ Artificial Joints
- ☐ High Cholesterol
- ☐ Bleeding disorder
- ☐ HIV

- **Date of last flu vaccine:**
- **Date of last pneumonia vaccine:**
- **Date of last mammogram (women):**
- **Date of last colonoscopy:**

Clinician signature:_____ **Date:**_____