

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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain or discomfort | <input type="checkbox"/> | <input type="checkbox"/> | Restless legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Legs feeling heavy | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged leg veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps | <input type="checkbox"/> | <input type="checkbox"/> | Skin color changes on the leg |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg burning, itching | <input type="checkbox"/> | <input type="checkbox"/> | Blood clots, DVT, or phlebitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg swelling | <input type="checkbox"/> | <input type="checkbox"/> | Leg ulcerations |
| <input type="checkbox"/> | <input type="checkbox"/> | Are any of these symptoms worse with prolonged standing or sitting? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any vein procedures in the past (surgical or cosmetic)? | | | |

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

- | | | | |
|--------------------------|--------------------------|---|------------------|
| YES | NO | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication (including over the counter) | List: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg elevation | How often: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Regular exercise | How often: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your job require prolonged sitting or standing? | |
| <input type="checkbox"/> | <input type="checkbox"/> | 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:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoker? _____ Packs per day? _____ Years? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Former Smoker? When did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drink alcohol? If yes, how many times in the past year have you had 4 or more alcoholic drinks in a day? _____ |

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

Men only—Do you have a history of varicose veins of the scrotal area? 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 or 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:

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

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

Clinician signature: _____ **Date:** _____