Health History- **Please complete all fields.**

Name _____ Date of Birth _____

How did you hear about us? _____ Weight_____ Height_____

Which of the following varicose vein symptoms do you have? Please check all that apply.

□ Pain
□ Aching / throbbing
□ Leg heaviness or fatigue
□ Restless legs
□ Swelling
□ Cramps/Charlie horses
□ Itching
□ Heat /burning over veins
□ Easy bruising
□ Skin discoloration
□ Ulcers or skin breakdown/bleeding

Other _____

Which leg? □ Both □ Right □ Left

How long have you had symptoms? _____

Which of the following make your varicose vein symptoms **worse**? Please check all that apply.

□ Sitting
□ Standing
□ Walking
□ Working
□ End of day
□ Pregnancy/Menstration

Other _____

Which of the following **improve** your symptoms? Please check all that apply.

□ Elevation
□ Rest
□ Start of day
□ Compression stockings
□ Pain medications
□ Walking / exercise

Other _____

On a 0-10 scale (10 being the worst), how bad are your symptoms? _____

Have you ever had any of the following vein treatments?

□ Vein stripping / ligation □ EVLT or RFA Vein Ablation □ Sclerotherapy (injections)

If yes, **when** were the treatment(s) done, **which leg** was treated, and **who** did the procedure?

_____

Have you ever worn *prescribed* medical stockings, and if so, for how long? _____

Have you ever had a blood clot called a DVT in your leg(s)? □ Yes □ No

Have you ever had leg pain attributed to your leg *arteries*? □ Yes □ No

Please list any past surgeries: _____

Please list any diseases or medical conditions **you** have been diagnosed with or treated for:

_____

_____

Do you have any allergies? (if yes, please specify)_____ _____

Please list any significant **family** medical history: _____

What medications do you currently take? _____

Are you on aspirin, Plavix, or Coumadin? _____

Do you drink alcohol?_____ If yes, how much? _____ Do you smoke?_____
If yes, how much?_____

Do you drink caffeine?_____ If yes, how much?_____

How many pregnancies have you carried to term?_____

Please circle any of the following that you have:

Heart disease/coronary artery disease

Cancer (type_____)

Diabetes

HIV/AIDS

Bleeding disorder

Hepatitis

Clotting disorder

Claudication (pain walking long distances)

COPD

Anemia

Asthma

Fever/Chills

Weight loss

Heart palpitations

Chest Pain

Difficulty breathing while lying down

Shortness of breath

Cough

Coughing up blood

Nausea

Vomiting

Abdominal pain

Blood in stool

Numbness/tingling in the legs/feet