East Tennessee
VEIN CLINIC

Patient History

Name: ___________________________________ **Date:** _____/____/______ **Age:** _________

Please check leg symptoms you currently have or have experienced in the past 3 months:

	Right	Left
no symptoms	☐	☐
aching	☐	☐
restlessness	☐	☐
heaviness	☐	☐
itching	☐	☐
burning	☐	☐
cramping	☐	☐
throbbing	☐	☐
fatigue	☐	☐
swelling	☐	☐
other:_______________	☐	☐

Do your symptoms interfere with sleep? ☐-Yes ☐-No
Do they interfere with walking? ☐-Yes ☐-No

On a scale of 1-10, with 1 being *slightly bothersome* and 10 being, *severely affecting my life*, I consider my vein disease to be:
1 2 3 4 5 6 7 8 9 10

Are your varicose or spider veins located in another area besides your leg? If so, where?

____

____

Please check if you have ever had:

	Right	Left
☐leg ulcers	☐	☐
☐bleeding from a vein	☐	☐
☐blood clot/phlebitis	☐	☐
☐vein surgery	☐	☐
☐prior vein evaluation/treatment	☐	☐
☐vein injections	☐	☐
☐leg injury/trauma	☐	☐

☐heart disease ☐ high blood pressure
☐hepatitis ☐HIV *(AIDS)*
☐cancer ☐diabetes
☐migraine

Do you have a family history of?
☐heart disease ☐leg ulcers ☐diabetes
☐varicose veins ☐clotting disorders

Do you smoke? ____. Packs per day ___

Do you drink alcohol? _____

OTC Medications/Prescription	Allergies

(Please list on back, if more space is needed)

Please check Yes or No:

I have tried elevation of my legs to relieve discomfort for _______ months. ☐-Yes ☐-No

I have tried elastic support/compression stockings. ☐-Yes ☐-No

If Yes: What type? How long?

____

I have taken medication for my leg symptoms. ☐-Yes ☐-No

If Yes: What medication? How long?

____

Standing makes my symptoms worse. ☐-Yes ☐-No
I stand _____________ hrs. per day.

Please list any surgeries/hospitalizations *(other than vein surgeries)* and month/year:

____

____

____

____

Please list your occupation:

____

<u>For Women only:</u>

Are you pregnant or considering pregnancy in the near future? ☐-Yes ☐-No

Are you breastfeeding? ☐-Yes ☐-No

Worsening of symptoms during pregnancy? ☐-Yes ☐-No

Worsening of symptoms around menstrual cycle? ☐-Yes ☐-No

Number of pregnancies? _____. Deliveries?_____

Do you use birth control pills or take estrogen replacement therapy? ☐-Yes ☐-No

Signature:

____