TENNESSEE VEIN CENTER

LEG VEIN MEDICAL HISTORY

Date: ________________________

Name: ____ ***Sex***: M F ***Age:*** ______ ***Height:*** ________ ***Weight:*** ________

What is the reason for you visit? ____

Which leg is bothering you? Right ☐ Left ☐ Both ☐ **If both, which leg is worse?** Right ☐ Left ☐ They are about the same ☐

Leg Symptoms (check all that apply)

- Pain and aching ☐
- Tiredness or Fatigue ☐
- Itching or Burning ☐
- Cramping ☐
- Restlessness ☐
- Throbbing ☐
- Ankle or Leg Swelling ☐

Symptoms Occur With: (check all that apply)

- Prolonged Sitting ☐
- Prolonged Standing ☐
- Lying Down ☐
- Working ☐
- End of the Day ☐
- Strenuous Activity ☐
- Walking ☐

Conservative Treatment Attempted

- Tylenol, Motrin or similar ...... Yes ☐ No ☐
- Leg Elevation ...... Yes ☐ No ☐
- Exercise or Walking ...... Yes ☐ No ☐
- Weight Loss ...... Yes ☐ No ☐
- Job Change ...... Yes ☐ No ☐
- Rest ...... Yes ☐ No ☐
- Compression Hose ...... Yes ☐ No ☐

Medical History

Do you smoke? .... Yes ☐ No ☐
Do you drink alcohol? .... Yes ☐ No ☐

Check if you've had any of the following:

- Coronary Artery Disease ☐
- Diabetes ☐
- High Blood Pressure ☐
- Hepatitis A ☐
- Hepatitis B or C ☐
- HIV / AIDS ☐
- Peripheral Vascular Disease ☐
- Leg Trauma ☐
- Cancer ☐

If yes, type of Cancer ______________

Is the cancer active? .... Yes ☐ No ☐

Surgical History

Coronary Artery Bypass ...... Yes ☐ No ☐
Peripheral Arterial Surgery .. Yes ☐ No ☐
Angioplasty / Stenting .... Yes ☐ No ☐

Medications

Are you taking

aspirin daily? .... Yes ☐ No ☐
warfarin (Coumadin)? .... Yes ☐ No ☐
birth control pills? .... Yes ☐ No ☐
hormone replacement? .... Yes ☐ No ☐

Other Medications:

______________ ______________
______________ ______________
______________ ______________
______________ ______________

Allergies

______________ ______________
______________ ______________

Venous Medical History

Have you had a prior vein evaluation? Yes ☐ No ☐ If yes, when ________________

How long have your varicose veins/leg symptoms been present? ________________

Do you have varicose/spider veins other than the legs? Yes ☐ No ☐

Check if you have had any of the following venous complications:

Bleeding from a vein ☐ Phlebitis ☐ Venous Ulcers ☐ Venous Dermatitis ☐

Deep Vein Thrombosis (DVT) ☐ If DVT, which leg and when ________________

Check if you have had any of the following vein treatments:

Vein Stripping or Phlebectomy ☐ If so, which leg(s) and when ________________

Endovenous Laser or Closure™ ☐ If so, which leg(s) and when ________________

Sclerotherapy ☐ Dermal (surface) laser ☐ Veinwave™ ☐

Please answer the following:

Do you have a clotting disorder? Yes ☐ No ☐ If so, type ________________

Women: Number of Pregnancies? _____ Ages of children ________________

Could you be pregnant? Yes ☐ No ☐ Are you breastfeeding? Yes ☐ No ☐

If you have leg symptoms, are they worse during menstruation? Yes ☐ No ☐

Check if any that are true regarding a family history of vein disease:

Varicose Veins ☐ Phlebitis ☐ Venous Ulcers ☐ Clotting Disorder ☐

Deep Vein Thrombosis (DVT) ☐ What family member(s)? ________________

*Signature:*________________________________ *Date:* ____________

Internal use: ____

____
____
____
____
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Right Left