



Patient Venous History

Patient Name: _____ DOB: _____

What is the main reason for your visit today? _____

How long have you had this problem? _____ Years _____ Months

Please **check** which symptoms you have:

- Leg Pain
- Itching
- Leg Cramps
- None
- Tired/Heavy Legs
- Aching/Throbbing
- Open Sore/Ulcer
- Other: _____
- Tenderness
- Burning
- Red Warm Areas
- Ankle Swelling
- Stinging
- Restless Legs

On a scale from 0 (**none**) to 5 (**severe**), how would you rate your symptoms? _____

Have your symptoms /veins gotten worse in the recent months? No Yes

Are your symptoms worse with?

- Prolonged sitting /standing
- Hot Baths
- Menstrual Cycle

Are your symptoms improved by?

- Rest and Elevation
- Walking

How do your symptoms alter your daily activities at work/housework? _____

How do your symptoms alter your leisure activities? (such as sports, hobbies, social life, family) _____

Do you stand much at work/home? No Yes

How does standing affect your legs? _____

Do you need to rest/elevate your legs at the end of your day? No Yes

Do you exercise regularly? No Yes

Describe activity _____

Have you ever worn **prescription** compression stockings? No Yes If yes; For how long? _____

Date first worn? _____ First prescribed by? _____

Pressure: 15-20mmHg 20-30 mmHg 30-40 mmHg

Type: Knee-Hi Thigh-Hi Pantyhose

Any improvement of symptoms with stockings? No Yes

Have you taken any medications (prescription / over the counter) for your symptoms? No Yes

Name and Strength? _____ How many times per day? _____

Name and Strength? _____ How many times per day? _____

Any improvements of symptoms with medications? No Yes

Have you ever had treatment for veins? No Yes If yes, explain: _____

Patient Signature: _____ Date: _____