



# 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: \_\_\_\_\_