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: _____

_____
_____
_____
_____
_____

Right Left