VENOUS HEALTH HISTORY FORM

PATIENT NAME _____ DATE OF BIRTH _____

PLEASE COMPLETE QUESTIONS 1-12. PROVIDE ESTIMATES FOR DATE OF OCCURRENCE.

PAST MEDICAL HISTORY

1. HAVE YOU EVER HAD VEIN STRIPPING SURGERY? ____YES ____ NO
   IF YES, WHEN AND WHICH LEG? _____
2. HAVE YOU EVER HAD VEIN INJECTIONS? ____YES _____ NO
   IF YES, WHICH LEG AND WHERE ON THE LEG? _____
3. HAVE YOU EVER HAD A BLOOD CLOT? ____ YES _____NO
   IF YES, WHICH LEG AND WHEN? _____
4. HAVE YOU EVER HAD PHLEBITIS? ____ YES _____ NO
   IF YES, WHICH LEG AND WHEN? _____

FAMILY HISTORY

5. DOES ANY ONE IN YOUR FAMILY HAVE OR DID HAVE VARICOSE VEINS, SPIDER VEINS, LEG ULCERS OR SWOLLEN LEGS?

   FATHER _____ YES ____NO BROTHER(S) ____ YES ____NO

   MOTHER _____ YES ____NO SISTER(S) ____ YES ____NO

   OTHER _____ YES ____ NO

PERSONAL HISTORY

6. DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOUR LEGS?
   a. ACHING/PAIN ____YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs
   b. HEAVINESS ____ YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs
   c. TiIREDNESS/FATIGUE ____ YES ____ NO During activity or prolong standing?
      ____YES ____ NO ___RT Leg ___ LT Leg ____ Both Legs
   d. ITCHING/BURNING ____YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs
   e. SWOLLEN ANKLES ____YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs
   f. LEG CRAMPS ____YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs
   g. RESTLESS LEGS ____YES ____ NO During activity or prolong standing? ____YES ____ NO
      ___RT Leg ___ LT Leg ____ Both Legs

h. TROBBING ____YES ____ NO During activity or prolong standing? ____YES ____ NO
___RT Leg ___ LT Leg ____ Both Legs

7. RATE THE INTENSITY OF YOUR PAIN ON A SCALE OF 1-10 WITH 10 BEING THE HIGHEST _____
8. IS THE PAIN PERSISTANT? _____ YES _____ NO
9. HAVE YOUR VEINS GOTTEN WORSE IN RECENT MONTHS? _____ YES _____ NO
10. DO YOU TAKE ANY MEDICINE FOR PAIN (i.e. ADVIL/MOTRIN) _____ YES _____ NO
    a. IF YES, WHAT MEDICATIONS AND HOW MUCH AND HOW MANY TIMES PER DAY?
    _____
11. DO YOU ELEVATE YOUR LEGS TO RELIEVE DISCOMFORT? _____ YES _____ NO
    a. IF YES, HOW LONG PER DAY DO YOU ELEVATE THEM AND DOES IT PROVIDE RELIEF?
    _____
12. DO YOU EXERCISE? _____ YES _____ NO
    a. IF YES, WHAT KIND OF EXERCISE AND HOW OFTERN?
    _____
13. DO YOU WEAR PRESCRIPTION COMPRESSION STOCKINGS? _____ YES _____ NO
    a. IF YES, WHAT TYPE AND GRADIENT? _____
    b. HOW LONG HAVE YOU WORN THEM? _____
    c. WHAT IS THE NAME OF THE PHYSICIAN THAT PRESCRIBED YOUR STOCKINGS AND WHEN WERE THEY ORDERED? _____
14. DO YOU HAVE ANY WALKING PROBLEMS? _____ YES _____ NO
    a. IF YES, DESCRIBE HOW IT INTERFERES WITH YOUR ACTIVITIES OF DAILY LIVING. (i.e. work/shopping/showering/cleaning/playing with children, etc.) _____
    _____
    _____
    b. IS IT WORSE AT NIGHT/ AFTER STANDING OR SITTING FOR LONG PERIODS / OR AFTER EXERCISE? _____ YES _____ NO
15. WHAT TYPE OF WORK DO YOU DO? _____
    a. HOW LONG DO YOU STAND (HOURS PER DAY) AT WORK? _____
    b. AT HOME? _____
    c. DESCRIBE HOW YOUR SYMPTOMS INTERFER WITH YOUR ESSENTIAL JOB FUNCTION OF YOUR OCCUPATION (WHICH ACTIVITIES ARE IMPACTED) _____
    _____
16. HAVE YOU HAD ANY TEST(S) DONE ON YOUR VEINS? _____ YES _____ NO
    a. IF YES, WHEN AND WHAT TYPE OF TESTS AND WHAT LEG? _____
    _____
17. WERE YOU EVER DIAGNOSED WITH *SAPHENOUS VEIN REFLUX*? _____ YES _____ NO
18. NAME OF REFERRING PHYSICIAN AND LENGTH OF TIME YOU HAVE BEEN UNDER HIS/HER CARE FOR TREATMENT OF THIS CONDITION _____

PATIENT SIGNATURE _____

DATE _____

PHYSICIAN TO COMPLETE

DATE OF INITIAL PHYSICIAN EVALUATION _____

CHECK ALL THAT APPLY:

- ☐ REVIEWED VENOUS HISTORY
- ☐ PHYSICAL EXAMINATION OF THE AFFECTED LEG(S) PERFORMED
- ☐ EDEMA SEVERITY TEST COMPLETED
- ☐ DUPLEX OR DOPPLER SCAN ORDERED OF THE AFFECTED LEG(S)
- ☐ GRADUATED ELASTICIZED COMPRESSION STOCKINGS (30-40 MMHg), PRESCRIPTED BY A PHYSICIAN NOT IN OUR PRACTICE, HAVE BEEN USED BY THE PATIENT FOR AT LEAST 90 DAYS
- ☐ PRESCRIPTION FOR GRADUATED ELASTICIZED COMPRESSION STOCKINGS GIVEN TO PATIENT _____ TODAY _____ AT AN EARLIER DATE (PROVIDE DATE) _____
  LENGTH OF TIME TO BE WORN _____
- ☐ CLINICAL NOTES RECEIVED FROM REFERRING PHYSICIAN
- ☐ OTHER CAUSES OF PATIENT'S LEG(S) SYMPTOMS HAVE BEEN RULED OUT
- ☐ INSTRUCTIONS GIVEN ON MEDICATION DOSAGE
- ☐ INSTRUCTIONS GIVEN ON DAILY LEG ELEVATION
- ☐ INSTRUCTIONS GIVEN FOR MILD EXERCISE
- ☐ INSTRUCTIONS GIVEN FOR WEIGHT REDUCTION