

Patient Name _____

Patient's date of birth _____

Date _____



What specific signs/symptoms have you experienced in your legs?

- | | | |
|--|--|---|
| ☐ Leg aching | ☐ Leg fatigue | ☐ Leg pain |
| ☐ Leg burning | ☐ Leg heaviness | ☐ Leg restlessness |
| ☐ Leg cramping | ☐ Leg itching | ☐ Leg swelling |
| ☐ Leg discoloration | ☐ Leg jumpiness | ☐ Leg throbbing |

When did these symptoms start? (i.e. <1 yr, 1 yr, 5 yrs, 10 yrs) _____

Do you have symptoms in your:

- ☐ Right leg only ☐ Left leg only ☐ Both legs

If one leg bothers you more than the other, which leg is worse? _____

Please check the following conditions that apply to you personally.

- | | |
|---|--|
| ☐ No Past Medical Problems | ☐ Blood Clots or phlebitis (Circle one) |
| ☐ Arthritis | ☐ Diabetes |
| ☐ Cancer – Type: _____ | ☐ High Blood Pressure |
| ☐ Heart Disease | ☐ Kidney Disease |
| ☐ HIV/AIDS/Hepatitis | ☐ Lung Disease |
| ☐ Liver Disease | ☐ Seizure Disorder |
| ☐ Mitral Valve Prolapse/Heart Murmur | ☐ Thyroid Disease: ____hypo ____hyper |
| ☐ Stroke | ☐ Other: _____ |
| ☐ Varicose Veins | |

Please report any conditions that apply to your immediate family members. Please note in the space provided if they apply to your mother, father, sibling(s) or grandparent(s).

- ☐ No Family Health conditions

Blood Clots/Phlebitis: _____
Diabetes: _____
High Blood Pressure: _____
Liver Disease: _____
Mitral Valve Prolapse/Heart Murmur: _____
Seizure disorder: _____
Thyroid Disease: ____hypo ____hyper

Cancer/Type: _____
Heart Disease: _____
Kidney Disease: _____
Lung Disease: _____
Stroke: _____
Varicose Veins: _____
Other: _____

Please list all medications, hormones, birth control pills, vitamins, or supplements that you are currently taking. Please include the dose and how many times a day you take each medication:

- ☐ No current medications, vitamins, or supplements

Please list any surgeries you have had and the approximate date of each surgery.

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Surgery: _____ Date of surgery: _____

Are you allergic to latex? ☐ No ☐ Yes

Are you allergic to any medications, dyes, or foods? ☐ No Known Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Height: _____ Weight: _____

Do you smoke? ☐ No ☐ Yes If yes, how much per day? _____

Do you exercise? ☐ No ☐ Yes What activity and how often? _____

Ladies: # of pregnancies _____ # of children _____ Currently pregnant or nursing? ☐ No ☐ Yes

Vein-specific questionnaire:

Have your veins deteriorated in recent months? ☐ No ☐ Yes → How many months? _____

Do you elevate legs to relieve discomfort? ☐ No ☐ Yes

Have you ever worn compression stockings (even for short periods of time, such as during pregnancy, or after surgery or childbirth)? ☐ No ☐ Yes → For how long? (i.e. days, weeks, months, years _____

What strength? ☐ 10-20 mmHg ☐ 20-30 mmHg ☐ 30-40 mmHg ☐ Unknown

If you cannot wear compression stockings, why? _____

How many hours a day are you on your feet, on average? _____

Do your leg symptoms affect your ability to do home and work activities? ☐ No ☐ Yes

Have you ever taken any medication such as Tylenol or Advil for leg discomfort? ☐ No ☐ Yes

If yes, what medication have you taken? _____

For how many months/years have you taken it? _____

Have you had previous vein treatment? ☐ No ☐ Yes

If yes, what type of treatment? ☐ Surgical Stripping ☐ Sclerotherapy (injections)

☐ Endovenous Laser Treatment ☐ Radio Frequency Ablation ☐ Spider Vein treatment

☐ Phlebectomy ☐ Other _____

When was your treatment done? _____

Were your symptoms relieved? ☐ No ☐ Yes For how long? _____

Have you ever had a leg ulcer or slow-healing sore? ☐ No ☐ Yes

If yes, which leg? ☐ Right leg ☐ Left leg ☐ Both legs

Treatment received for the leg ulcer? _____

Your preferred pharmacy name and address: _____

Do you give us permission to view and record your medical and/or medication history (if available electronically)? ☐ No ☐ Yes

Name and Address of Primary Care Physician/Provider: _____

Did your Primary Care Provider refer you here? ☐ No ☐ Yes

If not, whom may we thank for the referral? _____

If we proceed with treatment, would you like us to send a letter to your Primary Care Provider to inform him/her of your treatment plan? ☐ No ☐ Yes

Patient Signature _____ Provider Signature _____