

## Venous History

Do you have any of the following symptoms in your legs? please check all that apply

Symptom	Right	Left	Both
Pain/Aching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/Edema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How **long** have you had these symptoms? \_\_\_\_\_

Are your symptoms **worse at the end of the day**?.....  Yes No

Does **elevating your legs** make the symptoms better? .....  Yes No

Have you taken Tylenol/Motrin/Advil for symptoms in your legs?.....  Yes No

Have you ever worn **support hose** .....  Yes No  How long? \_\_\_\_\_

Did wearing **support hose** make your legs feel better?.....  Yes No

Have you had any prior treatment for Varicose/spider veins?.....  Yes No

What type of treatment?....  **Vein Stripping** ,,,,,,,  **Injection** ,,,,,,  **Laser/RF**

Which Leg? .....  Right....,  Left.....  Both When? \_\_\_\_\_

Have you ever had or been treated for Leg **phlebitis** (vein inflammation)..  Yes No

Which Leg? .....  Right....,  Left.....  Both When? \_\_\_\_\_

Have you ever had or been treated for a **blood clot** in your leg?,,,,,,  Yes No

If Yes When? \_\_\_\_\_ Was a filter placed? .....  Yes No

Have you ever had or been treated for an **Ulcer** in your leg?,,,,,,  Yes No

Which Leg? .....  Right....,  Left.....  Both When? \_\_\_\_\_

Have you ever had or been treated for a **Broken Bone** in your Leg?,,.....  Yes No

Which Leg? .....  Right....,  Left.....  Both When? \_\_\_\_\_

Does anyone in **your family** have Varicose Veins?.....  Yes No

If **Yes** Who? \_\_\_\_\_

Has anyone in **your family** had **Blood Clots** in their Leg Veins ? ,,,,,  Yes No

If **Yes** Who? \_\_\_\_\_