Main Line HealthCare
Physician Network

Venous Health History Form

Name: _____ Sex: M F

Date of Birth:_____ Primary Care Physician:_____

Phone Number:_____ PCP's Phone Number:_____

Please answer the following questions.
Provide your best estimate for dates 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, when, which leg and where on the leg?_____
   _____

3. Have you ever had a blood clot? Yes No
   If yes, when and which leg?_____

4. Have you ever had phlebitis? Yes No
   If yes, when and which leg?_____

5. Do you experience any of the following?

Aching or pain in your legs?	Yes	No
Heaviness?	Yes	No
Tiredness or fatigue?	Yes	No
Itching or burning?	Yes	No
Swollen ankles?	Yes	No
Leg cramps?	Yes	No
Restless legs?	Yes	No
Throbbing?	Yes	No
Other_____	Yes	No

**If you responded yes to any of these questions, is it in just one or both legs?
Right Left Both

6. Have your veins gotten worse in recent months? Yes No

7. Do you take any medication for pain (ex. Advil, etc.) Yes No

If Yes, what medication and how often?_____

8. Do you elevate your legs to relieve discomfort? Yes No

9. Do you wear support hose prescribed by a doctor? Yes No

10. Do you wear light support hose (ex. Sheer Energy) Yes No

If Yes, do they provide relief? Yes No

11. Do you have any problems walking? Yes No

If Yes, how does it affect you?_____

12. Do you stand much at work? Yes No
at home? Yes No

13. Have you ever had any test(s) done on your veins? Yes No

If Yes, when, what type test and where on the leg?_____
_____

14. Were you diagnosed with saphenous vein reflux? Yes No

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs?

Father……. Yes No

Mother…….. Yes No

Brother(s)……. Yes No

Sister(s)……. Yes No

Other_____ Yes No

STAFF USE ONLY:
Ultra-Sound Recommended? Yes No **Revised 12-2014**