VEIN HISTORY FORM

Name: ____ Date: ______________

Age: ___________ Sex: M / F

Please answer the following questions

1. Which leg(s) would you like us to evaluate today? ☐ Right ☐ Left ☐ Both

2. Have you ever had your veins evaluated before? Yes No
   If so, when and where? ____

3. Have you ever had surgery on your legs for a venous or arterial problem(s)? Yes No
   If yes, what type of surgery and when? ____________________________________

4. Have you ever had vein stripping or ligation surgery? Yes No
   If yes, when and which leg? ____

5. Have you ever had Sclerotherapy, Laser (EVLT) or Radiofrequency (CLOSURE) treatments? Yes No
   If yes, when and which leg? ____

6. Have you ever had a blood clot in your legs? Yes No
   If yes, when and which leg? ____

7. Do you currently wear or have previously worn compression hose stockings? Yes No
   If yes, for how long and what level of compression? ________________________

8. Do you currently take analgesics (e.g. Ibuprofen, Aleeve, etc,) on a regular basis to help reduce the pain in your legs? Yes No

9. Have you gained or lost a significant amount of weight (e.g. 15-20 lbs) in the past year? Yes No

10. Were you referred to us by a physician? ____________________________________ Yes No
    If yes, by whom? ______________________________________

11. Did you hear about us through a newspaper? Yes No
    If yes, which newspaper? ____

Please circle the appropriate answer.

1. Does anyone in your family have varicose veins, spider veins, leg ulcers or swollen legs?
   - Father ……………………………………………………………………Yes No
   - Mother …………………………………………………………………...Yes No
   - Brother(s) ……………………………………………………………...Yes No
   - Sisters(s) …………………………………………………………...……..Yes No
   - Other ____

2. Do you experience any of the following?
   - a. Aching/pain in your legs……………………………………..…Yes No
   - b. Heaviness in your legs……………………………………..…Yes No
   - c. Tiredness/fatigue in your legs………………………………..…Yes No
   - d. Itching/burning in your legs……………………………………Yes No
   - e. Cramping discomfort in your legs?………..…………………..…..Yes No
   - f. Restless legs ……………………………………………………....Yes No
   - g. Throbbing in your legs……………………..…………….......Yes No
   - h. Leg ulcers ……………………………………………………Yes No
   - i. Other ____
     ____

3. Have your symptoms or the appearance of veins on your legs gotten worse in the past 6 months? Yes No

4. Do you find that elevating your legs helps reduce the pain? Yes No

5. Do you wear a support hose prescribed by a doctor Yes No
   If yes, what level of compression? ________________________________

6. Have your leg problems affected your work or home activities? Yes No
   If yes, how so? ____

8. Do you have any allergies? Yes No
   If so, list them ____

9. Do you take any blood thinners, aspirin, ibuprofen, vitamin E or iron supplements on a regular basis? If yes, which medication(s)? ______________________ Yes No

10. Are you taking birth control pills? Yes No
    If yes, please list name(s) ____

11. Are you taking the antibiotic Minocycline? Yes No

12. What is your occupation: ____

13. If you are interested in learning about any of our Aesthetic services, please circle:
    Botox, Juvederm, Kybella, Latisse, Laser hair removal, Laser skin rejuvenation, Cosmetic vein work

Signed: ________________________________ Date: ______________