Phoenix
Heart | Vein | Vascular

VENOUS HEALTH & HISTORY FORM

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	**Marital status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

SYMPTOMS

REASON FOR YOUR VISIT TODAY: _____

_____

NUMBER OF YEARS WITH SYMPTOMS, SPIDER VEINS OR VARICOSE VEINS: _____

Occupation: ☐ PROLONGED SITTING ☐ PROLONGED STANDING

Please check if you have had or currently have any of the following **Symptoms** in your Legs, Ankles or Feet within the past 6 months:

☐ Hurt/Pain/Throb/Ache/Burn/Sore ☐ Tired/ Heavy Feeling ☐ Cramping ☐ Other: _____

☐ Leg Swelling / Edema ☐ Itching ☐ Restless Legs ☐ Lymphedema

Please check if you have had or currently have any of the following within the past 6 months:

☐ Visible Veins/ Varicose Veins ☐ Sores/ Ulcers Below Knee ☐ Blood Clots in your legs (Superficial) ☐ Blood Clots in your legs (deep)

☐ Skin Color Changes Below Knee ☐ Bleeding from Veins

☐ Cellulitis / Skin infection ☐ Other: _____

Please tell us how your signs and symptoms **Negatively** affect your **daily life and activities**:
EXAMPLES: Unable to: ●work, ●do chores, ●care for family, ●travel, ●use stairs, ●heavy lifting, ●shopping, ●exercise, ●stand up after sitting for some time, ●walking, ●gardening etc…

(Please give us at least **TWO SPECIFIC** examples)

Example 1: _____

Example 2: _____

Example 3: _____

Please tell us about any and all methods you have used to help with the discomfort in your legs:

☐ Elevation of Legs

☐ Exercise: Walking or running

☐ Use of: Tylenol / Ibuprofen / Advil * (NSAIDS)

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

☐ Other: _____

☐ Use of Support / Compression Stockings/ Socks: * (Medical Grade)

☐ Given by Physician (Rx) ☐ Over the counter

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

Type: ☐ Panty Hose ☐ Thigh High ☐ Knee High

Results: ☐ Minimal relief ☐ Moderate relief ☐ Significant relief

PAST VENOUS MEDICAL HISTORY

☐History of **DVT** (Deep Vein Thrombosis / Blood Clots or Clotting disorder) ☐History of **PE** (Pulmonary Embolism)

☐Clotting Disorder: ☐Factor VI Leiden ☐Prothrombin gene mutation ☐ _____

☐ leg Injury ☐ Knee surgery ☐ Hip surgery ☐ other:_____

PREVIOUS VEIN TREATMENTS:

☐ Treatment done by: _____ ☐ What Clinic: _____

Treatment Method:

☐ Injections (Sclerotherapy) ☐ EVLT (laser procedure for Varicose Veins) ☐ Plebectomy (removal of veins)
☐ Laser for Spider Veins ☐ Stripping / Surgery ☐ Stents/ Filters: _____
☐ Other: _____

FAMILY VASCULAR MEDICAL HISTORY

☐History of **DVT** (Deep Vein Thrombosis / Blood Clots or Clotting disorder) ☐History of **PE** (Pulmonary Embolism)
☐History of Varicose Veins / Venous Disease

PAST CARDIOVASCULAR HISTORY

☐History of CHF (Congestive Heart Failure) ☐ High Blood Pressure ☐ Heart Attack
☐Diabetes

MEDICATIONS / ALLERGIES / SURGICAL HISTORY

Please list all **MEDICATIONS** that you are currently taking with dosage: (☐ SEE LIST)

_____
_____
_____
_____

ALLERGIES:

☐ (NKDA) No Known Drug Allergies **SKIN ALLERGIES:** ☐ Latex ☐ Skin Tape

_____ _____
_____ _____
_____ _____
_____ _____

PAST SURGERIES: (List with dates)

_____ _____
_____ _____
_____ _____
_____ _____

FOR WOMEN ONLY

☐ Date of last menstrual cycle: _____
☐ Trying to become pregnant
☐ Currently Pregnant (please inform medical staff)
☐ Breast Feeding
☐ Post Menopausal
☐ Number of Pregnancies: _____
☐ Number of Miscarriages/ Stillbirths: _____
☐ Veins on Vulva or Labia
☐ Pelvic Pain or Heaviness / Pelvic Congestion Syndrome
☐ Hysterectomy/Date: _____

SOCIAL HISTORY

☐ Caffeine: ☐ Daily ☐ Occasionally ☐ Never
☐ Alcohol: ☐ Daily ☐ Socially ☐ Occasionally ☐ Never
☐ Smoking: ☐ Daily ☐ Socially ☐ Occasionally ☐ Never ☐ Former: stopped_____