

ARLINGTON VASCULAR OFFICE

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Venous Health History Form

Patient Name: _____ Date of Birth: _____

Directions: Please answer the following questions. Provide estimated date 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, which leg and where on the leg? _____
3. Have you ever had a blood clot? Yes No
If yes, which leg and when? _____
4. Have you ever had phlebitis? Yes No
If yes, which leg and when? _____

Family History

1. Please list the signs and symptoms you have experienced (i.e., trouble with walking, swelling, pain, etc.) _____
2. Have your veins worsened in recent months? Yes No
Describe: _____
3. Are you currently taking pain medications (i.e., Advil, Motrin) Yes No
If yes, list medications with dosages and how many times/mgs per day:

4. Do your vein problems keep you from performing your normal daily activities? Yes No
5. Do you elevate your legs to relieve discomfort? Yes No
If yes, how long per day? _____
6. Do you wear prescription compression hose? Yes No
If yes, what type and gradient? How long have you worn them?

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____
7. Do you wear light support hose (i.e., Sheer Energy)? Yes No
If yes, do they provide relief? _____
8. Have you ever had any test(s) done on your veins? Yes No
If yes, please describe: _____