THE VEIN & AESTHETIC CENTER

Patient Vascular History Questionnaire

Name ____ **DOB:** __________________

1. Reason For Seeking Treatment (please check)

Cosmetic (improvement of appearance only) ________ Both___________

Medical (relief of symptoms) ________

2. Personal History of Varicose Veins or Spider Veins:

________ Number of Years

Yes No Related to Pregnancy?

Yes No Related to Accident/Trauma?

Yes No Are you developing new veins?

Yes No Are your present veins getting bigger?

Yes No Does your discomfort/leg pain interfere with your daily life activities please describe

____

Comments ____

Are Your Symptoms Worse with

Yes No Prolonged Standing?

Yes No Prolonged Sitting?

Yes No Menstrual Cycle?

Are Your Symptoms Relieved with:

Yes No Rest/Elevation of Leg(s)?

3. Do You Have? (Please check):

_______ Aching or throbbing

_______ Burning pain in legs

_______ Ankle/leg swelling

_______ Hard Lumps

_______ Itching

_______ Other ____

_______Red/warm area

_______ Skin Changes

_______Tenderness

_______Tired/heavy legs

_______ Leg pain

________ bulging veins

________ spider veins

________ night cramps

Are your symptoms present in _____R Leg ____L Leg ____Both Legs

Would you describe your symptoms as _____mild ____moderate ____severe

4. Vascular History (*Current or Past*)

Yes No Varicose Veins

Yes No Superficial Phlebitis

Yes No Deep Vein Thrombosis (blood clots)

Yes No Pulmonary Embolus

Yes No Leg Fracture

5. Previous Conservative Treatment

Yes No Have you ever worn compression stockings for your veins? When? _________

Yes No Did they help your symptoms (leg pain/swelling)?

Yes No Do you take pain medication (Advil, Tylenol, aspirin) for your leg pain/veins?

6. Previous Treatment History

Yes No Ligation Stripping Surgery If so, which leg? _______________When? _______________

Yes No Injection Treatments If so, when?____________

Yes No Laser Treatment If so, when? ____________

Yes No Other If so, when? ___________________________

7. Family History (please circle who has had similar problem)

Mother Father Sister Brother Grandmother Grandfather Aunt Uncle None

Yes No Varicose Veins

Yes No Deep Vein Thrombosis

Yes No Pulmonary Embolus

Yes No Bleeding Disorders

Yes No None

Patient Signature ____ Date_____________

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