The Corvallis Clinic™

Venous Health History Form

Patient Name: _____ Date of Birth: _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

Have you ever had vein stripping surgery	Yes	No
If yes, when and which leg? _____		
Have you ever had vein injections?	Yes	No
If yes, which leg and where on the leg? _____		
Have you ever had a blood clot?	Yes	No
If yes, which leg and when? _____		
Have you ever had phlebitis?	Yes	No
If yes, which leg and when? _____		

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

Impact on Daily Living

Do you experience any of the following in your legs?

Aching/pain?	Yes	No	LT	RT	Both
Heaviness?	Yes	No	LT	RT	Both
Tiredness/fatigue?	Yes	No	LT	RT	Both
Itching/burning?	Yes	No	LT	RT	Both
Swollen ankles?	Yes	No	LT	RT	Both
Leg cramps?	Yes	No	LT	RT	Both
Restless legs?	Yes	No	LT	RT	Both
Throbbing?	Yes	No	LT	RT	Both

Other?_____

Please indicate how your varicose vein symptoms significantly impact specific activities of daily living (excluding "at work" symptoms).

Do you have pain when taking a shower or bath?	*Yes*	*No*
Do you have any bleeding from the veins?	*Yes*	*No*
Does getting dressed hurt?	*Yes*	*No*
Does it hurt if you bump them?	*Yes*	*No*
Does it hurt to cross your legs?	*Yes*	*No*
Do you have pain with meal preparation?	*Yes*	*No*
Do you have pain when doing household chores?	*Yes*	*No*
Does it hurt to garden or mow the grass?	*Yes*	*No*
Do you have pain with exercise?	*Yes*	*No*
Do you have pain when grocery shopping?	*Yes*	*No*
Do you have pain when you bend or squat?	*Yes*	*No*
Does it hurt when you are sleeping?	*Yes*	*No*
Does it hurt when your dog or cat jump on your legs?	*Yes*	*No*
Does it hurt to sit for an extended period of time?	*Yes*	*No*
Does it hurt to stand for an extended period of time?	*Yes*	*No*
Have your veins gotten worse in recent months?	*Yes*	*No*

Describe: _____

Do you take any medication for pain (i.e., Advil, Motrin) Yes No

If yes, what medication do you take and how many times/mgs per day? _____

_____

Do you elevate your legs to relieve discomfort? Yes No

If yes, how long per day do you elevate and does it provide relief? _____

_____

_

Do you exercise? Yes No

If yes, what kind of exercise and how often? _____

Do you wear prescription compression stockings? 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? _____

Do you wear light support hose (i.e., Sheer Energy)? Yes No

If yes, do they provide relief? Yes No

Do you have any problem walking? Yes No

If yes, describe how it interferes with your activities of daily living, which activities?

_____

_____

What type of work do you do?

_____

How long do you stand (hours per day) at work? _____

At home? _____

Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities:

_____

_____

_____

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

If yes, when and what type of test and where on the leg?

_____

_____

Were you diagnosed with saphenous vein reflux? Yes No

Name of referring Physician: _____

How long have you been under their care for treatment of this condition?_____

Patient Signature: _____ Date:_____