

PREMIER VEIN CENTER

A. Venous Health History Form

NAME _____ DATE _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____

Home Phone: _____ Work Phone _____

Sex: M F Status: Single Married Divorced Widowed

Date of Birth _____ Age _____

Employer _____ Occupation _____

Employer Address _____

Primary Care Physician _____ Phone _____

Nearest Relative _____ Home Phone _____

Who should we contact in case of emergency? _____

Phone Number _____ Relationship _____

How did you hear about Premier Vein center, LLC _____

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

Past Medical History: Circle One

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? _____

Current Medications _____

Past Surgical History _____

Allergies to Medications _____

Any significant medical issues: _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers, or swollen legs? (Circle Yes or No)

Father	YES	NO
Mother	YES	NO
Brother(s)	YES	NO
Sister(s)	YES	NO
Other _____	YES	NO

1. Do you experience any of the following in your legs? (Circle Answer)

Aching/pain?	YES	NO	ONE LEG	BOTH LEGS
Heaviness?	YES	NO	ONE LEG	BOTH LEGS
Tiredness/Fatigue?	YES	NO	ONE LEG	BOTH LEGS
Itching/Burning?	YES	NO	ONE LEG	BOTH LEGS
Swollen Ankles?	YES	NO	ONE LEG	BOTH LEGS
Leg Cramps?	YES	NO	ONE LEG	BOTH LEGS
Restless Legs?	YES	NO	ONE LEG	BOTH LEGS
Throbbing?	YES	NO	ONE LEG	BOTH LEGS
Other? _____				

2. Have your veins gotten worse in recent months? YES NO

Describe _____

3. Do you take any medication for pain (i.e., Advil, Motrin)? YES NO

If yes, what medications do you take and how many times/mgs Per day?

4. Do you elevate your legs to relieve discomfort? YES NO

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

Venous Health History Form (Cont.)

5. Do you exercise? YES NO

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

6. Do you wear prescription compression stockings? YES NO

If yes, what type and gradient? How long have worn them? What is the name of the physician who prescribed them?

7. Do you wear light support hose (i.e., Sheer Energy)? YES NO

If yes, do they provide relief? _____

8. Do you have any problem walking? YES NO

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

9. What type of work do you do?

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

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

10. Have you ever had any test(s) done on your veins? YES NO

If yes, when and what type of test and the results

11. Were you diagnosed with saphenous vein reflux? YES NO

12. Name of referring Physician and how long have you been under his care for treatment of this condition?

Patient Signature:

_____ Date: _____

PATIENTS: Please stop here. The physician may go over additional questions with you.