Patient Venous History

VANISHING VEINS NORTHWEST
Services provided by Valley Radiologists

Patient Venous History

Patient Name: _____ **Date of Birth:** _____

	Please Circle	
1. Have you had any previous treatment(s) for varicose/spider veins?		
If yes, date(s) of treatment(s): _____	**Yes**	**No**
Type of agent(s) used, if known: _____		
2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis?	**Yes**	**No**
3. Do you have a family history of varicose/spider veins?	**Yes**	**No**
If so, relationship(s) to you? _____		
4. Are you currently, or have you been on any hormone therapy or birth control pills?	**Yes**	**No**
If so, please list: _____		
5. Have you had any pregnancies? If so, how many? _____	**Yes**	**No**
If so, did your varicose/spider veins increase after your pregnancies?	**Yes**	**No**
6. Do you wear support hose?	**Yes**	**No**
If yes, are they prescription or over the counter? _____		
7. Are you presently employed? If so, type of job: _____	**Yes**	**No**
How Long: _____		
8. Do you sit or stand for long periods of time?	**Yes**	**No**
How many hours per day? _____		
9. Do you take any medication for the pain in your legs?	**Yes**	**No**
If so, does it work?	**Yes**	**No**
10. Do you elevate your legs to relieve your symptoms?	**Yes**	**No**
If so, does it work?	**Yes**	**No**
11. Do you have any medication allergies?	**Yes**	**No**
If so, please list: _____		

Comprehensive History Checklist (Please check all that apply)

	Right Leg	Left Leg
Swelling	☐	☐
Pain	☐	☐
Tiredness	☐	☐
Sores	☐	☐
Skin Color Changes	☐	☐
Spider Veins	☐	☐
Varicose Veins	☐	☐

Patient Signature: _____ **Date:** _____